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HEALTHY SETTINGS

From Ideology to Practice

Canadian Case Studies

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HEALTHY SETTINGS

CANADIAN CASE STUDIES

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PREFACE

The report reflects the developing state of health promotion, both the concepts and the processes. It represents the continuing efforts to bring together for review initiatives from across the country, and continues the process of asking questions and finding new ways of interpreting and sharing overall knowledge.

The central aim of this report is to examine the relationship between settings and health by describing a selection of "healthy settings" programs from across Canada. This subject, building on recent publications of experts, is approached from a perspective that views settings, contexts and interrelationships in peoples' lives as determinants of health.

The report begins with a literature review which outlines the evolution of health promotion over the last several decades. This section shows how health promotion has evolved from a branch of medicine which encourages individuals to make healthy lifestyle choices, to a broad field that addresses medical and non-medical determinants of health, and looks at the conditions in which we live as fundamental to our health status. As such, the notion of health has broadened in its scope and we are faced, as health promotion theoreticians and practitioners, with ever increasing challenges in the field.

The second part of this report introduces the Canadian Case Studies. These are organized under two broad categories: Workplace Health and Community Health. As will be discussed in the introduction to the report, these divisions are flexible; health promoted in the community is health one brings to work, and one's experience at work is then brought home to the family.

ACKNOWLEDGEMENTS

Health Canada is grateful to MaryLou Harrigan and her research assistant, Esther Grunau, for researching and compiling this report.

Those who participated in the collection of these case studies are to be commended for their cooperation—the many individuals and organizations who gave freely of their time and shared their views and commitment to healthy settings. This report reflects their efforts and their attention to health promotion initiatives across Canada.

It is vitally important that practitioners and researchers working in every setting and at every level in Canada—in communities, provinces and national organizations—take part in the effort to expand the knowledge base and to communicate what they learn to others working in the field. The invitation is open.

—Health Canada 1989

INTRODUCTION

SECTION ONE

LITERATURE REVIEW

CHAPTER ONE

OVERVIEW

The literature review examines several developments in health promotion in Canada. Three main aspects are discussed:

MILESTONES IN HEALTH PROMOTION

A review of the literature demonstrates the evolution of health promotion as a discipline. Significant reports marking the history of health promotion are highlighted. These major planning reports include:

- *The Lalonde Report:* New Perspective on the Health of Canadians
- *The Epp Report:* Achieving Health for All: A Framework for Health Promotion
- *The Ottawa Charter*
- *Knowledge Development for Health Promotion:* A Call for Action
- *The National Forum on Health*

CURRENT PERSPECTIVES

A number of papers providing current perspectives on health promotion, population health, public health and community health are discussed.

SETTINGS APPROACH

While health promotion has pursued several approaches, e.g. issues and population, the "settings" approach has become more common recently and focuses particularly on settings.

BACKGROUND

Over the past 25 years the concept of health promotion has received increasing attention worldwide. In Canada, the initial interest in health promotion began with the Lalonde Report in 1974 and has continued throughout the eighties and nineties with a growing emphasis being placed on implementing strategies and programs aimed at population health and lifestyle improvement:

> *Health promotion is difficult to define. It is something quite original, which is not health care, or health education, or health administration, or public health, although these all form part of its lineage. Health promotion is more than the sum of its parts; it encompasses in a new synthesis elements of all the above health fields, as well as fields which in the past would have been regarded as falling outside of the health domain.* (Health Canada 1989)

As increasing attention has been paid to the concept of health promotion there has been an ongoing reassessment of what is meant by the word "health." During the 1970s in Canada, lifestyle and prevention were considered the dominant aspects of promoting health. The 1980s saw a shift toward looking at health as a function of the environment in which people live. Recent reports by Health Canada as well as academic papers suggest that health is determined by an even broader range of interacting issues. They indicate that the health of an individual is affected by a complex web of settings such as the workplace, school, institution, community and family, networks of other people, as well as by the interaction among these settings.

In the preamble to the World Health Organization Constitution, "health" has been defined as *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."*

This state of well-being is believed to provide the individual with an opportunity to conduct a socially and economically productive life. As health practitioners, promoters, related professionals and researchers, this concept of health is one held as an ideal to work toward. The principle is that Canadians, as a people, would be committed to working toward this ideal and to creating healthier people, communities, and settings.

MILESTONES IN HEALTH PROMOTION

A review of the literature demonstrates the evolution of health promotion as a discipline. The following synopsis highlights significant reports that mark the history of health promotion.

THE LALONDE REPORT

A New Perspective on the Health of Canadians, the Lalonde Report (Health Canada 1974), marks a major milestone in health promotion. Lalonde illustrates the need to give attention to human biology, the environment and lifestyle, and to aim toward preventing ill health:

> *At the same time as improvements have been made in health care, in the general standard of living, in public health protection and in medical science, ominous counter-forces have been at work to undo progress in raising the health status of Canadians. These counterforces constitute the dark side of economic progress. They include environmental pollution, city living, habits of indolence, the abuse of alcohol, tobacco and drugs, and eating patterns which put the pleasing of the senses above the needs of the human body.*

The Lalonde Report places emphasis on the individual personal accountability for health:

> *Most Canadians by far prefer good health to illness, and a long life to a short one but, while individuals are prepared to sacrifice a certain amount of immediate pleasure in order to stay healthy, they are not prepared to forego all self-indulgence nor to tolerate all inconvenience in the interest of preventing illness.*
>
> *The behaviour of many people also reflects their individual belief that statistical probability, when it is bad, applies only to others.... Yet, when sickness strikes, the patient expects rapid, quality care; all available resources must be marshaled on his or her behalf with little regard for cost.*

The report outlines the ways in which Canadians can improve upon this situation, including data to support the arguments. These are traditional population health arguments.

THE EPP REPORT

The landmark report, *Achieving Health for All: A Framework for Health Promotion* (Health and Welfare Canada 1986), describes a new vision of health which revisits and reinforces earlier ideas and seeks to make them relevant to contemporary problems.

The framework for health promotion identifies health challenges, health promotion mechanisms and implementation strategies as major elements.

The national health challenges which need to be met in order to improve health and quality of life in Canada are reducing inequities, increasing the prevention effort, and enhancing people's capacity to cope.

The mechanisms intrinsic to health promotion are self-care, or the decisions and actions individuals take in the interest of their own health, mutual aid, or the actions people take to help each other cope; and healthy environments, or the creation of conditions and surroundings conducive to health.

Implementation strategies include fostering public participation, strengthening community health services, and the coordination of healthy public policy.

The report illustrates the interrelationship of these elements, the challenges and strategies aimed at overcoming them, and what Epp refers to as health promotion:

> *...health promotion implies a commitment to dealing with the challenges of reducing inequities, extending the scope of prevention, and helping people to cope with their circumstances. It means fostering public participation, strengthening community health services and coordinating healthy public policy. Moreover, it means creating environments conducive to health, in which people are better able to take care of themselves, and to offer each other support in solving and managing collective health problems.*

This is a significant milestone—public policy acknowledges the need to create healthier environments, or **settings**, in relation to health.

THE OTTAWA CHARTER

> *Health promotion is the process of enabling people to increase control over, and to improve, their health.*
> —World Health Organization (WHO) 1987

The first International Conference on Health Promotion held in Ottawa in 1987 presented a Charter for action to "achieve health for all" by the year 2000 and beyond. Health promotion is defined in the Ottawa Charter as **health promotion action.**

According to the Charter, health promotion action means:

- ☐ **Building healthy public policy**
  It puts health on the agenda of policymakers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

- ☐ **Creating supportive environments**
  The inextricable links between people and their environment constitutes the basis for a socio-ecological approach to health.

- ☐ **Strengthening community action**
  Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health.

- ☐ **Developing personal skills**
  Health promotion supports personal and social development through providing information, education for health and enhancing lifeskills.

- ☐ **Reorienting health services**
  The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments.

The Ottawa Charter emphasizes the environment, the context of peoples' lives; that societies are complex and interrelated; that health cannot be separated from other goals; and that inextricable links between people and their environment constitute the basis for a socio-ecological approach to health. There is a focus on settings:

> *Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love.*

KNOWLEDGE DEVELOPMENT FOR HEALTH PROMOTION

The purpose of the report *Knowledge Development for Health Promotion: A Call for Action* (Health and Welfare Canada 1989) is to encourage and invite broad participation in the health promotion knowledge development process "and provide readers with a basis for putting health promotion into practice in their spheres." It serves to follow up and reinforce the concepts of principles proposed in the Epp Report. In proposing a new paradigm for health in Canada—one marked by socio-ecological, multidisciplinary orientation—the framework opens the way for fresh linkages to be made, and for the forging of new and refreshingly different kinds of relationships among the ever-widening circle of players in health.

The report discusses the key features of the Health Promotion Framework, knowledge development within the framework, and Canada's key research activities to date. It contains the *Research Reports*—summaries of literature reviews and research reports written by physicians and researchers from across Canada commissioned by the Working Group on Research Priorities in Health Promotion and Disease Prevention.

THE NATIONAL FORUM ON HEALTH

In 1994 Prime Minister Jean Chrétien launched the National Forum on Health "to involve and inform Canadians and to advise the federal government on innovative ways to improve our health system and the health of Canada's people" (National Forum on Health 1997). The Forum focused on long-term and systemic issues, and examined four key areas:

☐ Values
☐ Striking a Balance
☐ Determinants of Health
☐ Evidence-Based Decision Making

The Determinants of Health component of the National Forum sought to answer the question:

> *In these times of economic and social hardship, what actions must be taken to allow Canadians to continue to enjoy long life and, if possible, to increase their health status?*

This Working Group consulted experts to identify the non-medical determinants of health and to prepare papers on issues of concern to the health of the population related to the macro-economic environment, the contexts in which people live (e.g. families, schools, work and communities), and on issues which relate to people's health at different life stages.

The Forum concluded that the public needs more information and evidence on where promotion and prevention make a difference. The *Determinants of Health Working Group Synthesis Report* (1997) states:

> *There has been a great deal of discussion about the importance of personal health practices for the health of individuals and populations. While we have known for some time that poor health practices (such as smoking, poor eating habits or substance abuse) are determinants of ill health, we know that such practices are very much influenced by the social and economic environments in which people live and work. They involve less of an individual choice than was once thought.*

Among the values identified by the *Values Working Group Synthesis Report* is the belief that the health system ought to focus more on the broader determinants of health. The majority of participants in the Values Working Group survey, however, were reluctant to shift funds away from direct health care to pay for programs aimed at promoting the general health of the population. There was a clear indication, according to the report, that some participants viewed prevention in terms of making healthy lifestyle choices as largely a matter of personal responsibility. This view also contributed to the resistance toward reallocating resources from treatment to prevention; but once participants understood the connection between improvements in the environment, education and other indicators of socioeconomic status and improved health, some supported a shift in funding aimed at promoting the general health of the population.

Many health and social indicators are promising: life expectancy has increased while crime, injuries, per capita alcohol intake and smoking among males have decreased. But many people believe that other elements in our current economic and social environment put our health at risk. Child poverty, unemployment, youth underemployment, labour force restructuring, cuts in social programs, decreases in real income, income inequalities, the disintegration of communities as we once knew them and the ever-increasing pressures of work on families could lead to declines rather than increases in life expectancy. Among the worrisome signs are the increases in stress-related diseases and mental health problems associated with unemployment, increases in smoking rates among women, suicide rates among youth and continuing high rates of low birth weight babies.

Thus the Determinants of Health Working Group (1977) concludes that, in addition to continuing to adopt positive health practices to abate these types of health problems, we must now begin to focus more on *health* and less on *health care*:

> *We know that societies can improve or worsen their health by influencing the quality of the social environments in which people live and work.*

CURRENT PERSPECTIVES

There are a number of papers which provide current perspectives on health promotion, population health, public health and community health.

FEATURES OF THE NEW MOVEMENT

Prominent features of the new health promotion movement (Robertson and Minkler 1994) include:

- broadening the definition of health and its determinants to include the social and economic context within which health—or more precisely, non-health—is produced
- moving beyond the earlier emphasis on individual lifestyle strategies to achieve health to broader social and political strategies
- emphasizing the concept of empowerment—individual and collective—as a key health promotion strategy
- advocating the participation of the community in identifying health problems and strategies for addressing those problems

Labonte (1995) extends the existing understanding of health promotion:

> *Health is uncoupled from disease. The experience of "being healthy"...relies primarily upon desirable qualities in one's social relationships and circumstances. Health promotion practice is equally concerned with people's experiences of well-being...as with their physical functioning....*
>
> *Power is central to practice relations, specifically how the "power-over" tendencies of professionals and bureaucracies can be transformed to "power-with"....*
>
> *Health promotion is explicitly concerned with values and a vision of a preferred future. It bases its practice upon the need to discuss with other sectors, community groups and disciplines what type(s) of society, economy and political systems we want (and why).*

TENETS OF POPULATION HEALTH

Frank (1995) describes population health as including the following main tenets:

☐ Major determinants of health status are not medical care inputs and utilization, but cultural, social and economic factors at both the population and individual levels.

☐ At population level, societies in which there is both a high level and relatively equitable distribution of wealth enjoy a higher level of health status.

☐ At individual level, one's immediate social and economic environment and the way that this environment interacts with one's psychological resources and coping skills has much more to do with the determination of health status than was earlier recognized.

☐ There are causal pathways, with profound public health implications for prevention, linking the early childhood environment to major illnesses and deaths later in life.

☐ Health policies and research must take a broad multi-sectoral view, and attempt to integrate biological, social and economic considerations of health.

CRITERIA FOR HEALTH PROMOTION

Poland (In Press) suggests the following criteria for distinguishing health promotion:

☐ encouraging public participation by individuals and communities
☐ taking a social and cultural perspective in understanding and responding to health issues and problems
☐ emphasizing equity and social justice
☐ fostering intersectoral collaboration
☐ including physical, mental, social and spiritual dimensions of health
☐ focusing on enhancing health, and not just on preventing problems

Poland purports that many activities carry the label of "health promotion" in Canada whether they meet all or even some of the criteria derived from theoretical writings about health promotion. In Canada, the following types of activities have been funded and carried out in the name of health promotion:

- mass media campaigns to increase awareness of the dangers of smoking and drinking and driving
- comprehensive school-based health education programs
- mobilizing community concerns about heart health, low birth weight and other prevention issues
- community development projects focused on enabling disadvantaged mothers to enhance their parenting skills
- enabling workplaces to assess and deal with lifestyle and environmental issues
- building coalitions to respond to cutbacks in services
- lobbying for changes in smoking and other health-related policies
- enhancing the preventive practices of physicians and other health care workers
- social support interventions for disadvantaged persons and caregivers

Poland argues that while it is tempting to view only those activities that meet at least one of the criteria as falling under the rubric of health promotion, this would exclude a wide range of interventions which nonetheless make a contribution to promoting health.

POWER AND EMPOWERMENT

As attention shifts to health promotion over time, there is an increasing emphasis on the concept of "empowerment" and its relationship to the notions of health and community participation.

Labonte (1994) focuses on the notion of empowerment as a central theme in health promotion and discusses how power is used in the dialectic between the public, professionals and the government and other bureaucracies in health.

This new health promotion movement has resulted in a fundamental shift in the ways in which many health professionals think, talk, and write about health, the determinants of health, and the strategies for achieving health. Both the philosophical core and one of the central strategies of the new health promotion are articulated in the concept of *empowerment.*

> *"Empowerment" represents a primary criterion for identifying health promotion initiatives. An initiative can be classified as a health promotion initiative if it involves the process of enabling or empowering individuals or communities.*
>
> —Poland et al. In Press

SETTINGS APPROACH

Over time health promotion has pursued various approaches:

- ☐ The **issue approach** includes issues such as alcohol or drug problems, AIDS, safety, or obesity.
- ☐ The **population approach** identifies a population of concern such as homeless people, seniors or adolescents, and makes efforts to address their concerns, whatever they may be.
- ☐ The **setting approach** (which has become more common recently) focuses on a particular setting such as school, workplace, or the community:

> *The concept of "setting" is fundamental to theory and practice in health promotion, because it delineates boundaries conceptually and in terms of target populations, as well as framing the context within which health is influenced (the setting itself as a target of intervention).* (Poland et al. In Press)

Shain (1995) summarizes the movement in health promotion toward examining settings as determinants of health, not simply as avenues through which to educate people about health:

> *Traditionally, health promotion theory saw settings as ways of "getting at" issues—e.g. reaching smokers* through *the workplace or* through *the school. But evidence has been accumulating showing that settings themselves are important influences on health practices and health conditions. For example, it is clear that the ways in which institutions such as schools, workplaces, hospitals, correctional facilities and so forth are run (managed) has a vital effect upon the well-being of those who reside in them, whether as staff or as consumers/ clients/ recipients of some service or product delivered by them.*

One common factor linking settings and health is the concept of "psychosocial hazards." These hazards are created or abated by the ways in which people who live in close relationships with one another behave toward each other. They can exist at a social level too, in societies that allow racism, bigotry, and other forms of intolerance to thrive. Frequently, psychosocial hazards have their origin in the abuse of power and the misuse of channels of communication.

INTERRELATIONSHIP AMONG SETTINGS

Current goals of public health are expanding. "According to the new, wider perspective, public health concerns extend beyond health protection and prevention " (Poland et al. In Press). These include:

- ☐ reducing the negative impact of a broad range of social, political and economic determinants of health
- ☐ giving attention to domains of health beyond the physical – that is, to include mental, social and spiritual dimensions
- ☐ enhancing health
- ☐ redistributing of power and control over individual and community health issues
- ☐ shifting the allocation of resources "upstream" toward prevention of problems before they occur
- ☐ taking an ecological approach to health that considers health the dynamic product of interactions between individuals and their environments
- ☐ recognizing community development and involvement as legitimate and effective strategies for maintaining and improving health

METHODOLOGY

CHAPTER TWO

...Most health promotion practitioners and researchers today are struggling to find some balance between objective health measures and subjective health experiences. As for "community (how defined?)," I would ask "what is a population?" A neighbourhood? A city? A province? A nation? Where are the boundaries drawn? More importantly, why are boundaries drawn and created in some instances, but not in others?

—Labonte 1995

OVERVIEW

Chapter Two describes the methods used in researching the initiatives, and how the report is organized. The study draws on two main sources:

☐ *the literature, particularly the National Forum on Health*
☐ *Health, Work and Wellness Conference held September 1997*

Two main categories of "healthy settings" are selected:

☐ *WORKPLACE HEALTH*
☐ *COMMUNITY HEALTH*

Case studies, identified in subsequent chapters, include a broad range of programs.

RESEARCH METHODS

A prime purpose of this report is to continue efforts of earlier work:

> *...to stimulate all relevant parties, particularly those from beyond the traditional health sphere and those outside the governmental structure, to become involved in health promotion, to ask questions and to find new ways of interpreting and using the answers and sharing overall knowledge.* (Health and Welfare Canada 1989)

Broadening the perspective of "health" guided our approach to researching case studies across the country:

> *In proposing a new paradigm for health in Canada—one marked by a socio-ecological, multidisciplinary orientation—the framework opens the way for fresh linkages to be made, and for the forging of new and refreshingly different kinds of relationships among the ever-widening circle of players in health. By shifting the focus from an individual to a broader environmental perspective, the framework invites the involvement of disciplines, sectors and interests which have not previously been accustomed to regarding health as their domain.* (Health and Welfare Canada 1989)

The study draws on two main sources to identify the settings and health models:

- ☐ the literature, and in particular the National Forum on Health
- ☐ the Health, Work and Wellness Conference held in Vancouver in September 1997

The Health, Work and Wellness Conference provided an overview of what the experts in the field of work and health are saying, and distilled the main themes of their arguments. At the conference there appeared to be a consensus among the leaders in the field on a number of issues. They felt that health should be understood in the broadest sense and that this understanding should include the physical, psychological and social well-being of the individual. In addition to individual health, attention must also be paid attention to the health of the actual settings in which one works, lives and operates on a daily basis. There was a repeated call for a shift in the way the promotion of healthy settings is viewed. This shift moves away from the traditional focus on healthy behaviours, education and awareness campaigns aimed at individual responsibility to lead a healthy lifestyle. It moves toward the adoption of an approach which focuses on creating healthy settings.

Case studies were identified by delegates of the Health, Work and Wellness Conference, and others were referred by experts in the field.

Each initiative is described by a leader involved in the wellness program. Material for the case studies was provided by contributors via several methods, including completion of a questionnaire (Appendix A), personal interviews and reports. Appendix B lists the contributors to facilitate further communication and networking.

LIMITATIONS

Poland (In Press) states "one of the key factors behind the increased interest in the settings approach has been the ecological perspective of health promotion, demanding that individuals not be treated in isolation from the larger social units in which they lived, worked and played." However, he acknowledges several limitations to the ecological view of health promotion:

☐ Ecological approaches are complex.

☐ Ecological approaches are less amenable to traditional forms of evaluation than are clinical interests.

☐ Ecological complexity breeds despair: ". . . the ecological credo of everything influences everything else, carried to its logical extreme, leaves health practitioners with little basis on which to set priorities. They have good reason to do nothing because the potential influence of or consequence on other parts of an ecological system are beyond comprehension, much less control . . . "

☐ The level of analysis is very observer-dependent.

ORGANIZATION OF THE REPORT

The report is organized to illustrate the variety of ways in which health is being promoted, maintained and encouraged in communities including workplaces, families, schools, hospitals and regions. The report presents a range of programs, projects and models that are currently in use across the country, a snapshot of healthy settings:

> *... the conceptualization of Issues and Settings as a fluid, interactive system of influences directs our attention to the desirability of planning health promotion and disease/ injury prevention interventions* across *issues and settings wherever possible. As noted earlier, this is probably the key to a successful population health strategy.* (Shain 1995)

The literature supports viewing health promotion through the "settings" approach. In this report two main categories of healthy settings are selected:

☐ Workplace

☐ Community

The case studies include a range of programs.

There is a recognition in health promotion that environment is a factor that predisposes, enables, and reinforces individual and collective behaviour. Its implication for health promotion planning and evaluation is that there is nothing inherently superior or inferior in any health promotion method or strategy. Planning for a setting as a focus of health promotion can be more adaptable and sensitive to particular traditions, cultural variations, and circumstances (Poland et al. In Press).

> *Much as it might be ideal to find every activity planned and conducted in the spirit and letter of the broader, ecological definitions of health promotion, practitioners and program managers know that this is impracticable. What makes a community's or nation's many health promotion activities add up to an ecologically sound health promotion program is their combined effects. A community or state accomplishes the fullness of health promotion not by insisting that each activity achieve that fullness, but by ensuring their mutual complementarity, their coverage of the full range of population groups in an equitable fashion, and their distribution of effort at many levels of intervention in many settings.*
>
> —Poland et al. In Press

CASE STUDIES

SECTION TWO

OVERVIEW

The case studies that follow illustrate the broad range of initiatives underway across Canada. These studies include a variety of processes and programs in different environments.

The examples of case studies range from well-funded programs established by large corporations to minimally funded programs established by small groups.

Themes throughout the case studies promote:

- ☐ *collaboration and partnership*
- ☐ *commitment, empowerment, ownership*
- ☐ *cultural change*
- ☐ *quality improvement concepts and principles*
- ☐ *education, "the learning organization"*

The case studies fall into two main categories: Workplace and Community.

The fluidity of setting boundaries is very apparent in the review of the cases. Several of the case studies could fall in either the Workplace chapter or the Community chapter. The first case study in this section, the Centre for Work and Health, is such an example.

As well, the Community Health Initiatives section and Community Partnerships section are not totally distinct. Many of the case studies in the former section involve partnerships and collaboration as well.

WORKPLACE HEALTH

CHAPTER ONE

For health promotion to improve in effectiveness, it is time for professionals to adopt a more balanced approach and direction to programming that includes individual responsibility and health behaviours, and addresses psychosocial and socio-ecological issues—namely the work people do and the cultural context in which it is done.

— Peterson 1997

OVERVIEW

Chapter One first highlights current themes from the literature pertaining to the workplaces.

Case studies are then presented under the following three categories:

CORPORATE SETTINGS
- *Heart and Stroke Foundation, New Brunswick*
- *NBTel, New Brunswick*
- *BC Telephone Company, British Columbia*
- *Montreal Worksites, Quebec*

HEALTHCARE INSTITUTIONS
- *Four Facilities, British Columbia*
- *Vancouver Hospital, British Columbia*
- *Healthcare Benefit Trust, British Columbia*
- *Sherbrooke Community Centre, Saskatchewan*

SHIFTWORK AND COMMUNITY NEEDS
- *Keyano College Lifestyle Services, Alberta*
- *Aspen Regional Health Authority, Alberta*
- *RCMP Health Services, Alberta*

The case studies are divided into eight headings following the questionnaire (Appendix A):
- *Initiative*
- *Leadership*
- *Needs Assessment*
- *Goals*
- *Process*
- *Ongoing Commitment and Leadership*
- *Model/ Framework*
- *Evaluation*
- *In Your Opinion*

CURRENT THEMES

WORK AND CULTURE

> *When the workplace consists of a culture that values worker health and psychological needs, the potential for increased productivity and improved well-being is enhanced.*
>
> —Peterson 1997

Peterson (1997) offers specific suggestions for health promotion professionals:

- ☐ Provide expertise on how to modify jobs so that they are less stressful mentally and physically, and thereby enhance health and ultimately productivity.
- ☐ Provide educational workshops and skill training that impact management practices, work conditions and stress.
- ☐ Assess work culture and its impact on stress and health and identify high-risk areas, departments, and jobs for intervention.

Further, the literature suggests "a spillover effect from job to leisure, indicating that people who hold stimulating jobs might be more likely to engage in physical activity and other healthy behaviours" (Peterson 1997).

The literature also supports the concept that workers who are satisfied with their jobs tend to be healthier, whereas "people who are dissatisfied with their jobs incur negative physical and psychological consequences" (Peterson and Wilson 1996).

HEALTH, WORK AND WELLNESS CONFERENCE, 1997

The Health, Work and Wellness Conference, held September 1997 in Vancouver, put forward several current themes. In the opening plenary session of the conference, Labonte of Communitas Consulting summarizes this change in emphasis through his critique of traditional workplace health promotion: "It has spent far too much time concentrating on making *workers healthier* rather than making *healthier workplaces.*"

In keeping with this theme, John Frank of the Institute for Work and Health pointed out that one often hears about problems in the area of worker's compensation and the quantity of work, but fails to talk about the *quality* of work as a public health concern. He argued that "bad work" is linked to disease, and that the design of work impacts on people's health status.

Michael Peterson of the University of Delaware introduced the notion of "Organizational Health" which acknowledges the importance of employee *and* organizational wellness.

Labonte's closing remarks offered a continuing optimism in the face of what may appear to be insurmountable barriers to workplace health. He suggested that it is not wrong to continue working on health risk assessments and lifestyle programs, but that it is in danger of being insufficient. To address this concern, Labonte suggested that the boundaries in "wellness within the workplace" be made more permeable. For example, he stated the emphasis in a stress prevention program should be not only on personal coping and lifestyle issues, but rather on allowing the boundaries between the *personal,* the *organizational* and the *social* to become more fluid.

WORKPLACE DETERMINANTS OF HEALTH

A number of factors contribute to workplace injuries and illnesses. Strategies to improve adverse conditions must address determinants both inside and outside the workplace.

Individual factors: Individual worker characteristics (e.g. gender, smoking, socioeconomic status), non-work demands (e.g. childcare, elder care) and personal resources (e.g. education, family or social support) are correlated with injury and disability.

Job factors: The pace and value of work, level of worker participation in decision-making, management philosophy, the repetitiveness of tasks and the range of skills used place physical and psychosocial demands on workers and are related to health outcomes.

Organizational factors: Terms of employment (e.g. level and method of remuneration and benefits), shiftwork versus regular working hours, decision-making latitude and structures, commitments to health and safety, and on-site facilities are variously correlated with such indicators as lost-time injury rates, job satisfaction, productivity and mental health.

External factors: Globalization, economic competition, the drive to increased productivity and the changing structure of business have led firms to invest in workers and to compromise working conditions, contributing to, and prejudicing, health.

While links between these factors and injury rates, lost time, productivity and profits are clear, links between these factors and health outcomes are less so. Correlation can be established, but it is often difficult to infer causality or determine its direction.

ASSESSING WORKPLACE IMPACTS

The literature suggests three categories of workplace approaches:

☐ **Occupational health and safety**

These efforts focus on reducing workplace toxicity and harm and have contributed to the reduction of exposure to unsafe work and a decline in fatal accidents. The challenge is to successfully address new conditions such as soft tissue injuries, sick building syndrome, and psychological and psychosocial problems.

☐ **Workplace health promotion**

These approaches seek to reduce the risk of illness through workplace education, skills development and support programs. Evaluations reveal improvement in some health behaviours and individual health status (e.g. blood pressure control, smoking cessation); other studies are more tentative, with causality generally difficult to establish. One model—Health Canada's Workplace Health System—is noted for its broader effort to integrate individual and organizational factors. The failure of most workplace strategies to integrate these factors is one of several serious limitations of these approaches.

☐ **Organizational change**

These are usually top-down approaches, focusing on improving worker functioning through changing attitudes and perceptions (e.g. training, goal setting and team building) or changing job structures (e.g. work content and job enrichment). Emphasis has usually been on improved job satisfaction or productivity and has not generally been extended to worker health. When it has been, impacts on health outcomes appear mixed.

THE WORKPLACE HEALTH SYSTEM (WHS): A HEALTH CANADA INITIATIVE

The workplace program within Health Canada (HC) has taken a comprehensive (determinants of health) approach to health promotion. The goal is to provide opportunities for Canadians—employers and employees— to improve and maintain their health through the workplace environment.

Health Canada is responding to:

☐ the need for and benefits of a comprehensive and integrated health promotion approach within the work environment

☐ the need for and benefits of a safe and supportive work environment

☐ need for knowledge, skills and resources by the private sector to address concerns at the workplace level

☐ the need for leadership, advice, training and support to key stakeholders involved in workplace settings

With the increased awareness of the determinants of health, importance of a safe, healthy and supportive workplace and the growing dissatisfaction with approaches which focus primarily on personal lifestyle changes and ignore such important factors as the physical and social environment, a new approach to workplace health promotion was required. In order to help address this need, achieve the goal of "healthier workplaces" and provide opportunities for people through the workplace to establish and maintain good health, Health Canada developed the Workplace Health System (WHS). This model is designed to bring together many of the health issues/determinants of health within a settings approach. The necessary resource materials, training and research are also being provided and developed in support of the provincial and local partners, key stakeholders involved in the promotion and implementation of the WHS.

PRINCIPLES

The Workplace Health System is based on five guiding principles:

☐ Meet the needs of all employees, regardless of their current levels of health.

☐ Recognize the needs, preferences and attitudes of different groups of participants.

☐ Recognize that an individual's "lifestyle" is made up of an independent set of health habits.

☐ Adapt to the special features of each work environment.

☐ Support the development of a strong overall health policy in the workplace.

These principles are linked to another important premise, that creating a healthy workplace requires addressing three major avenues of influence on health:

☐ Environment (physical and psychosocial) considers factors in the work environment that affect health, such as air, noise and light conditions, safety of machinery and equipment, the type of work, responsibilities at work, organization and design of work, interpersonal relations within the workplace and at home.

☐ Personal Resources considers the sense of influence employees feel they have over their health and work, how much social support they feel they receive from others and the degree to which they actively participate in improving their own health.

☐ Health Practices considers practices that affect health, including exercise, smoking, drinking, sleeping and eating habits, as well as the use of medication and other drugs.

IMPLEMENTATION

The WHS follows a seven-step implementation process: commitment, workplace health committee, needs assessment, workplace health profile, health plan, program action plan, and review of progress. WHS strongly encourages participation from all levels of the organization.

The WHS is currently implemented through three models. The Corporate Health Model is for organizations and businesses with more than 100 employees. The Small Business Health Model is for businesses with less than 100 employees. The Farm Business Health Model is for farm operators, their employees, and family members who work on the farm. Both the Small and the Farm Business Health Models use a community-based approach. (A comprehensive school health model for students from grades seven to twelve is being developed and is presently in the pilot phase.)

The models are coordinated through a Partner Network (see Appendix B) consisting of provincial and municipal public sector entities, NGOs, business and health agencies.

RELATIONSHIPS BETWEEN HEALTH AND WORK

Shain (1966) suggests "mapping relationships between work and health" in order to provide a "conceptual framework within which ongoing discussions about the relationships between work and health can be organized."

Polanyi et al. (1996) explain the limitations of three important areas of health promotion:

- ☐ Conventional workplace health promotion has focused on individual lifestyle factors while largely ignoring the way work conditions contribute to such behaviours.

- ☐ Occupational health and safety has traditionally emphasized the reduction of toxic exposure and physical demands, and has only recently started to deal with the effects of work organization and psychological demands on health.

- ☐ Organizational change interventions have been primarily oriented toward improving productivity and have treated worker health, if at all, merely as a means to that end.

Polanyi calls for the integration of efforts of the three areas to more fully address the organizational determinants of health.

> *New strategies are needed to reduce the heavy human and economic burden of workplace illness and injury. We believe that some organizational change strategies not usually explicitly linked to health outcomes, such as communication and problem-solving training, job enlargement and redesign, and participatory decision making approaches, may offer a fruitful path to healthier workplaces...Likewise, further improvements to worker health may require addressing fundamental social and psychological determinants of physical and mental health at the job and firm levels.*
>
> —Polanyi et al. 1996

The central message of the Ottawa Charter was that improving the health of individuals requires changing the social and economic *conditions* in which people live. Recently proponents of both *health promotion* and *population health* frameworks have called for even greater attention to the underlying social determinants of health such as income distribution, employment, and social support (Frank 1995; Labonte 1995).

Peterson (1997) is critical of traditional health promotion approaches at work:

> *An individually based program emphasis may neglect the most important factors that influence behaviour—in the work environment, these factors are the organizational culture and the work people do.*
>
> *...Leaders in health promotion have been advocating a cultural approach, [however], this cultural approach to programming has been designed to facilitate individual health behaviour change at work, not to improve the cultural and psychosocial antagonists to health from work. Consequently, benefits are realized, but they are also limited, for the stresses and demands within the workplace and organization have not been removed. ... Occupational stress and mental health are still elusive issues for many health promotion programs.*

CORPORATE SETTINGS

CASE STUDIES

WORKPLACE WELLNESS

Heart and Stroke Foundation, New Brunswick

WELLNESS PROGRAM

NBTel, New Brunswick

A NEW WAY OF THINKING AT WORK

BC Telephone Company, British Columbia

WORKPLACE SANCTUARY

Montreal Worksites, Quebec

The field of health promotion must understand the foundational principles that drive corporate culture and business and begin to recognize and confront the harmful aspects of these principles while upholding the positive virtues inherent within. A question the profession must ask is, how can a worksite health promotion program be effective if the work environment prevents involvement in programs, contributes to psychosocial stress and strain, or predisposes workers to negative coping behaviours?

—Peterson 1997

WORKPLACE WELLNESS

Heart and Stroke Foundation, New Brunswick

INITIATIVE

The Workplace Wellness initiative originated in 1988 when a large company in New Brunswick, NBTel, asked for a representative from the Heart and Stroke Foundation to speak to their employees about the signals and actions of a heart attack (after a young employee died in the workplace of cardiac arrest). For the next two years a series of presentations were given on a variety of heart health related topics. The Foundation Health Promotion Committee (then titled the Education Committee) saw an opportunity to broaden the scope and reach many "at risk" people by developing a Workplace Wellness Program. A Workplace Wellness Planner was introduced to the province in 1991.

LEADERSHIP

Health Promotion staff, with input from the volunteers, have been the driving force of this initiative from the beginning. Free consultative services have been available to any worksite in New Brunswick interested in creating a health promotion plan for their workplace. This consultation is generally provided to an existing Health and Safety Committee, or an Employee Assistance Program Committee, to assist with creating a new Wellness Committee.

NEEDS ASSESSMENT

The original Workplace Wellness Planner included a simple needs assessment. In 1993 the Wellness Check, a computerized lifestyle assessment tool, was developed as part of a three-year demonstration project that partnered the Heart Health Project with the Foundation and NBTel. The Wellness Check gave employees an opportunity to indicate their areas of interest in wellness activities at the worksite. It did not do a needs assessment of the corporation or the corporate culture. The information gathered shaped the implementation of programs as requested by the employees.

GOALS

The goals of a given workplace wellness initiative varied from business to business. The goals were primarily health-related.

PROCESS

Again, this varied from worksite to worksite. In each case the needs assessments were summarized; the working wellness committee determined the actions and goals, and submitted a budget plan to management for approval. Based on the monies received, the implementation process was put into place.

Worksites were encouraged to have short- and long-term goals. A number of resources were provided at little or no cost so that the implementation process could proceed even if funds were limited.

A variety of education tools were available and used by companies and businesses throughout the province. They ranged from no cost to high cost, depending on the resources available to the committee.

ONGOING COMMITMENT AND LEADERSHIP

The Foundation has remained committed to this process since the onset in the late 1980s.

- ☐ Three provincial workshops/conferences were hosted over the past four years. Attendance grew from 100 at the first to 200 at the most recent event in April 1997.
- ☐ The Health Promotion Committee of the Heart and Stroke Foundation has also formed a working group of volunteers including the health promotion manager who works to improve wellness in all worksites in New Brunswick. The Foundation continues to support the health promotion manager in this area as a "no-cost service" to interested worksites.
- ☐ A wide variety of resources continue to be offered to worksites at little or no cost. The working group is organizing regional workshops for interested worksites to meet and share ideas and challenges. This is also an opportunity to present information on the importance of a healthy corporate culture.

MODEL/FRAMEWORK

The framework until now has focused primarily on the individually oriented lifestyle education, awareness and behaviour model of health promotion. Work is currently underway to expand the focus and model to assist with the creation of healthy corporate and community culture.

EVALUATION

The original model and hosting of Workplace Wellness Conferences has increased the awareness of the importance of this type of initiative in many worksites throughout New Brunswick. There are several "shining examples" (like NBTel) where a wealth of wellness activities has started to bring awareness to the necessity of taking personal responsibility for one's health. The time is right to grow and "move on" to expand the focus to a healthy corporate culture.

IN YOUR OPINION

Though we have not conducted a formal evaluation of our outcomes, I feel what we have done so far has had a measure of success based on the enormous interest in the area of Workplace Wellness. We certainly can't take credit for every positive thing that has happened in this area in New Brunswick, but I do believe that we have contributed significantly to the process by providing resources and information and personal assistance with the process for many worksites. I also believe that it is time to 'expand our horizons'. The reduction of heart disease and stroke is still our ultimate goal, and the worksite is full of people who are at risk. Improving corporate and community culture as well as providing opportunities for people to learn and have positive behaviours supported are all essential to that process. I expect our Foundation will remain involved in this initiative for a number of years. There are always things you could do differently but, overall, I feel that we have progressed well and learned from our mistakes. It is an exciting area to be involved with in New Brunswick.

WELLNESS PROGRAM

NBTel, New Brunswick

INITIATIVE

The idea for this project originated when the Heart and Stroke Foundation of New Brunswick and Heart Health (a provincial government division) requested a partner in business for a study. NBTel was asked to be that partner.

The Wellness Program was initiated in 1994.

LEADERSHIP

The Human Resources Department provided leadership with the commitment of the vice president of that area.

A part-time employee was designated to initiate the program using Wellness Committees within each of the regions.

NEEDS ASSESSMENT

☐ Regional needs assessments. To "kick off" the program, Wellness Fairs were held. This included a needs assessment questionnaire. Many employees attended one of these Wellness Fairs in the region. Peoples' needs and desires on a regional basis were then known, enabling the needs assessors to assess on a regular basis.

☐ The Wellness Committee's structure was modeled after NBTel safety structure. This consisted of regional wellness committees and one governing body called the Provincial Wellness Committee.

☐ A signed and supported Wellness Policy Statement was developed.

☐ The outcome of the needs assessment identified issues that interested employees in each region. For example, over 90 percent of smokers wanted to quit, but did not want NBTel's help in their effort to quit. Therefore, no effort was put into a smoking cessation program.

☐ The information was used to shape the implementation process (for example, if a region was interested in more physical activity, time was directed into club memberships or building a gym).

GOALS

☐ The Wellness Policy states that NBTel is dedicated to the well-being of its employees as defined by the United Nations: *Wellness is not only the absence of illness but also the sense of total physical and mental well-being.*

☐ Committees work on activities that contribute to good employee health and provide opportunities for employees to engage in healthy lifestyles. Decreasing absenteeism is considered when planning activities.

PROCESS

A regional committee approach promotes activities that should meet the needs of the employees in that region.

ONGOING COMMITMENT AND LEADERSHIP

Upper management support of the program is excellent. A problem is that the executives are not sufficiently involved. Problems are in the line management area where sometimes wellness activities are viewed as time away from the job and not beneficial.

Some staff support the Wellness Program and some do not feel it is of benefit.

MODEL/FRAMEWORK

The focus to date has been on very specific activities such as stress seminars, nutrition sessions, walking clubs, and participation challenges. In time it is hoped to look at wellness from a lifestyle approach.

EVALUATION

There has been no formal evaluation of the impact of this process.

A NEW WAY OF THINKING AT WORK

BC Telephone Company, British Columbia

INITIATIVE

BC Telephone Company (BC TEL) has had corporate health services initiatives in place since as early as 1946. The Employee Assistance Program was started in 1971 with alcohol-related issues as its main focus. It has evolved into a program that does broad corporate social work, providing assessment and referrals for employees who need help coping with problems.

BC TEL also provides eight staffed fitness centres and three unstaffed centres where employees can have access to both the facilities, fitness education, and personal trainers.

Human factor specialists, who consult on all major workplace and process design and do ergonomics assessments of existing workstations, have been on staff since 1992.

LEADERSHIP

BC TEL's approach to health care is captured in the mission statement of the Corporate Health Services Department:

> *To enhance organizational competitiveness and optimize individual health.*

NEEDS ASSESSMENT

Various studies were done, including "Work and Family," "Supportive Manager" and "Pulsecheck." All of these studies indicated increasing levels of stress. In addition, corporate health records indicated more stress-related illnesses and increasing absenteeism.

GOALS

Corporate Health Services has been optimizing occupational health for more than fifty years, ensuring that employees receive professional and confidential health care through the following services:

☐ occupational health
☐ employee fitness
☐ human factors
☐ employee assistance

The goal of Corporate Health Services is to support the employee in the management of health. This goal is achieved through the promotion of wellness and lifestyle initiatives, ergonomic intervention, fitness facilitation, and employee assistance counseling.

Corporate Health Services has a professional staff comprised of occupational health nurses, fitness professionals, employee assistance counselors, human factors specialists, and administrative support staff who are committed to helping employees develop a healthy approach to personal excellence.

PROCESS

The role of Corporate Health Services is to assist the employee in managing health by providing current information or programs related to:

☐ lifestyle changes and choices
☐ illness and injury management
☐ workplace health and safety
☐ self-care of minor health complaints
☐ stress reduction and management of change
☐ Employee Assistance Program (EAP) assessment and referral
☐ health screening services (hearing testing, vision screening, cholesterol testing, blood pressure monitoring)

The employee's first introduction to Corporate Health Services occurs with an initial health review, which is usually arranged by the employment staff. The Occupational Health nurse reviews the employee's history and performs a vision screening, hearing test and a brief physical assessment. This assessment provides baseline information that is helpful in comparing any changes in health over time. This helps the employee to stay healthy and enjoy an active and productive lifestyle.

The centres are open during normal business hours and employees are invited to drop in for treatment of illness and/or injury, and for lifestyle discussions.

Health promotion programs and lending library resources are available for employees.

ONGOING COMMITMENT AND LEADERSHIP

BC TEL strongly believes that investing in the health of its employees is investing in the health of the organization. The company has been providing occupational health services to its employees for 51 years, has sponsored an Employee Assistance Program since 1971, fitness programs since 1977, and ergonomics programs since 1992.

MODEL/FRAMEWORK

The Manager of Corporate Health Services has developed most of the programs available today during her 24-year tenure with the company. The entire program, including Occupational Health, the Employee Assistance Program, and Ergonomics and Fitness, is overseen by the Corporate Health Services Department. Programs are offered to all employees of the company through a variety of approaches such as on-site education and visits, the Internet, 1-800 lines, regional health and fitness centres, and face-to-face meetings.

EVALUATION

The program is constantly evolving to meet the needs of employees. Quarterly reviews of the statistics are conducted, and adjustments to the programs are made to meet the requirements of the employees.

IN YOUR OPINION

I have been with Corporate Health Services for the past 24 years and have been instrumental in development of most of the programs available today. My current role as Manager of Corporate Health Services is to oversee the management of the complete program.

We consider our program to be an outstanding success. This is based upon utilization, reduction of absenteeism statistics, and ongoing support by the employees and the organization over the past 50 years.

Our challenges continue to be the ongoing demonstration of the value of our programs to the organization and its employees and to address the ever-changing wellness needs.

WORKPLACE SANCTUARY

Montreal Worksites, Quebec

INITIATIVE

A Work Enjoyment Survey is a tool used to calibrate how well people feel in the workplace and to focus a group analysis and cultural inventory. This requires not only improved communication and collaboration but also explores the root cause of any distress and examines the core values of the organization.

LEADERSHIP

The senior-most management/leadership must take ownership of this process. One can build from a grass roots level, but if the process is not supported or understood at the top, any positive results tend to be sabotaged.

NEEDS ASSESSMENT

Focus groups and the Work Enjoyment Survey are the methods used to analyze needs in a given workplace. The outcomes of the assessment are then discussed with a management team. After a period of analysis and reflection, the team looks at the training and development needs, and coaching needs. Health in the context of the "healthy work environment" is incorporated into all planning and subsequent training activities. Participants are encouraged to talk openly about their expectations of work, how they wish to be treated and their expectations of others.

Outcomes of the needs assessments fall into core issues around:

- ☐ Competency: learning opportunities within the workplace and the ability to maintain one's mastery
- ☐ Chemistry: relationships between people at work, the presence or absence of empathy, truth telling and promise keeping
- ☐ Delivery: the ability to listen to and meet the needs of both internal and external customers

GOALS

Goals are identified around the core values of Mastery, Chemistry and Delivery.

PROCESS

☐ Process used: Individual and team coaching, workshops, integration of values into key committees/departments within the organization

☐ Steps: Dependent upon each organization

☐ Education Tools: Work Enjoyment Survey, values-centered leadership assessment, experiential learning through case study, problem solving, games, MBTI Personality Preferences, asking questions, coaching

ONGOING COMMITMENT AND LEADERSHIP

This depends upon the organization. Typically, the public sector has much less available in terms of resources.

MODEL/FRAMEWORK

The model used is derived from two primary sources:

☐ Values-centered leadership
☐ The five disciplines of the learning organization

Central to the work is the notion of work and the human spirit: that work needs to support the spirit as well as the mind and the body. The notion of a workplace sanctuary is described and the extent to which individual worksites are or are not sanctuaries is determined. Within the values-centered model there are five shifts that need to be addressed by organizations if spirit is to build at work:

☐ from "me" to "you"
☐ from weaknesses to strengths
☐ from breakthrough to kaizen
☐ from things to people
☐ from fear and competition to love and caring

This model provides a comprehensive approach by which teams, leaders and departments can guide their work. It can be applied to planning, decision making, team development and performance.

EVALUATION

This is ongoing and informal.

IN YOUR OPINION

Based on my perception of the process, I do believe this model is successful. It is simple for people to understand and relate to, although most admit it is difficult to do every day. Response to date, however, has been very positive as people are in desperate need of having more meaningful work and relationships at work. They want to feel inspired and not tired.

I am not the creator of the model but have developed my own tools and materials to interpret the model and create the experiences. I am usually responsible for initiating the program along with key managers and leaders in the organization. Beyond initiation I try to have a role as an external coach, as one-time training is generally ineffective.

I work with a network of consultants to continue the development of our work. Those of us involved have access to many tools through the Secretan Center.

I am constantly assessing ways to provide different delivery. Each project is unique and I attempt to understand the lessons and apply the learning.

Challenges encountered in implementing our process:

☐ *Unsupportive CEOs*

☐ *High conflict within the organization*

☐ *High levels of ongoing changes*

☐ *Canadian companies controlled by American partners*

HEALTH CARE INSTITUTIONS

CASE STUDIES

HOSPITAL WELLNESS PROJECTS
Four Facilities, British Columbia

WORKPLACE WELLNESS: WELLNESS WORKS
Vancouver Hospital, British Columbia

WORKPLACE HEALTH PROMOTION
Healthcare Benefit Trust, British Columbia

WOW: WORKING ON WELLNESS PROGRAM
Sherbrooke Community Centre, Saskatchewan

CAREGIVER PROGRAM
Casey House Hospice, Ontario

HOSPITAL WELLNESS PROJECTS

Four Facilities, British Columbia

INITIATIVE

The Corporate Health Model (CHM) developed by Health and Welfare Canada sparked the beginning of participatory action research sponsored by the Population Health Resource Branch of the B.C. Ministry of Health, which began in January 1990. Several pilot projects were established throughout the province in worksites that included a sawmill, a college, a public health unit, a social services branch, a small town and a hospital.

From these pilot organizations was learned the strengths and weaknesses of the CHM. It was learned that this process always takes time—usually about a year of once a month full-day meetings—and that rushing compromises quality; that each group is very different, both in the speed with which it is able to implement the process and the various issues and barriers that the group confronts; that the group's ability to self-determine the areas of the inquiry is key to an effective set of recommendations (health plan); and that external facilitation is key to the success of the project in unionized settings. The process was adjusted to reflect this experience, adding a step to the process (determining the areas of inquiry), developing a bank of questions in response to sites' requests, and using external facilitation.

In November 1994 the Ministry of Health agreed to fund four facilities to conduct a three-year Workplace Health Pilot Project. The four facilities were:

☐ Langley Memorial Hospital is a 417-bed community hospital serving the City of Langley, the Township of Langley and Cloverdale. The hospital provides primary care, specialized services, and extended care, and employs 1173 individuals for a total of 650 full-time equivalent positions.

☐ Queen's Park & Fellburn Care Centres were formerly known as Pacific Health Centre. Queen's Park Care Centre (New Westminster) is a 300-bed long-term and rehabilitation centre in the Simon Fraser Health Region, employing approximately 600 individuals.

Fellburn Care Centre is a 110-bed extended-care centre in the Simon Fraser Health Region, employing approximately 225 individuals.

In total the two centres have approximately 420 full-time equivalent positions.

- ☐ Peace Arch Hospital is a 552-bed (177 acute care and 375 extended care) community hospital serving the City of White Rock. The hospital provides acute care, specialized services, and extended care, and employs approximately 1300 individuals for a total of approximately 740 full-time equivalent positions.

- ☐ St. Mary's Hospital is an 83-bed community hospital serving the Township of Sechelt and the Sunshine Coast: Gibsons, Sechelt, and Pender Harbour. The hospital has 33 acute and 50 extended care beds, and employs 285 individuals for a total of 185 full-time equivalent positions.

The objectives of the project were:

- ☐ Enhance the health, well-being and safety of health care providers in the workplace.

- ☐ Develop a collaborative, stakeholder-driven process for initiatives that positively influence the working environment in the health care sector, decrease the likelihood of illness or injury to employees and improve attendance rates.

- ☐ Demonstrate cost savings in the areas of sick leave, Workers' Compensation, and Long Term Disability at the pilot sites.

After exploring several different avenues to achieve these objectives, the Project Steering Committee in September 1995 decided to use a health promotion approach proposed by the Population Health Resource Branch (PHRB) of the Ministry of Health. The agreement between the four facilities and the Ministry was amended to run from November 1995 to March 1998.

LEADERSHIP

Leadership was provided by the Pilot Project Working Committee which guided the project, and was composed of a project manager from the Ministry of Health, the provincial nurse advisor until December 1996, and senior human resources representatives from each of the participating sites.

The project demanded a high level of commitment and participation from the organizations' senior management and the full cooperation of the three unions.

In addition to an incentive grant provided by the Ministry of Health, the project received financial support from the British Columbia Health Association Healthy Hospitals Project and the Population Health Resource Branch of the Ministry of Health. Each of the sites was responsible for backfilling the committee members, printing and distributing the survey.

Site committees were created from existing Occupational Health & Safety (OH&S) Committees on all four sites. The committees met once a month (except July and August) from October 1995 to December 1996. At each of the sites participants were supported through external facilitation to develop a vision of their organization as a healthy workplace.

Health care OH&S Committees are typically composed of union and management representing a fairly broad cross-section of the hospital including front-line workers. The degree of personal experience with this type of project typically varies widely among committee members.

The Queen's Park and Fellburn OH&S Committees were brought together to form one committee which they called the "Workplace Health Committee." The St. Mary's OH&S Committee nominated several of its members to the committee, expanded the membership to represent the worksite as a whole, and named themselves the "Healthy Organization Committee." The Peace Arch OH&S Committee formed the base of the committee, added more members to reflect its workforce, and named itself the "Healthy Workplace Project Team." The Langley OH&S Committee retained both its name and its original membership.

NEEDS ASSESSMENT

Needs assessment exists at two levels: at the workplace, where goals and needs are identified, and at the health promotion process itself. Each of the committees developed a vision of their organization as a healthy workplace. Goals were developed to address the gap between what committee members believed existed now and their preferred future. Queen's Park and Fellburn Care Centres worked as individual groups through this phase, deciding to combine their visions and goals when they could see the similarities.

The committees looked at current communication routes in their facilities and developed plans to address ongoing communication with their co-workers.

Committees developed a list of unknowns or questions relating to each one of their goals. These questions guided the development of areas of inquiry to direct the process of issue identification. Each committee adapted the same generic question bank to reflect their areas of inquiry. Additional question sets were developed to cover areas not contained in the question bank or when committees wished to examine a specific area more closely. Additional question sets were developed in such areas as recognition, quality and use of information sources, feedback, conflict resolution, and teamwork. Question sets were shared among committees when areas of inquiry were similar.

Distribution plans were produced by each site detailing how the surveys would be distributed and returned. Respondents were given the opportunity to either hand in their surveys for bulk mailing by the facility or mail their survey directly to the Population Health Resource Branch at the Ministry of Health.

Various strategies were developed to promote the process and elicit staff responses. Peace Arch hired a mime to kick off their survey day while St. Mary's hosted a staff tea. Queen's Park/Fellburn developed a unique poster series which was mounted in staff washrooms. Response to the survey reflected the degree of promotional effort by committees and their ability to make personal contact with staff.

The committees looked at health in its broadest context, at the everyday culture and activities in their workplaces and at the way they do things and how that affects their health.

GOALS

Some sample health plan recommendations are that:

☐ The factors be identified that contribute to the level of satisfaction with the challenge in their work experienced by non-clinical support workers

☐ Priority action be taken to review and improve orientation training in terms of its effectiveness, accessibility, and completeness at the work site level

☐ Priority action be taken to review and improve the accessibility and appropriateness of educational opportunities (including scheduling and funding)

☐ The hospital encourage and support the use of conflict resolution processes including the development and provision of opportunities to build knowledge and skills

☐ A strategy be developed to increase staff's awareness of how their role and those of others achieve the mission, for example, "a day in the life," job shadowing, role/service quizzes, orientation

☐ Current shift schedules be re-aligned to more closely meet the needs of individual shift workers without compromising the overall provision of patient/resident care

☐ Supervisors/team leaders be given opportunities to develop coaching/motivational skills which encourage their staff to actively participate in departmental operations

☐ Healthy food choices be offered in vending machines

☐ The integration of staff between the main hospital and extended care be improved

☐ Supervisors receive specific skills and process training in how to handle issues raised by staff and that staff receive specific skills and process training in how to bring forth issues to supervisors and co-workers

☐ A hospital-wide, zero-tolerance drug and alcohol policy be developed, implemented and stringently enforced so that individual employees feel safe and supported in acting under the policy

☐ The OH&S Committee determine employees' particular experience with feeling threatened by people they work with and make recommendations to improve these encounters

☐ Administration, in consultation with staff, look at ways of decreasing staff workload, including increased staffing, inter- and intradepartmental scheduling and the redistribution of patient care

PROCESS

Data entry and analysis were conducted off-site by the Population Health Resource Branch and the Merritt Group. An initial report provided each committee with the opportunity to look at "raw data" and to request specific data "sorts" based on their hunches. For example, some committees were able to establish direct links between workload, stress and absenteeism.

Each committee prepared comprehensive and specific recommendations based on these findings which were presented to the organization's senior management. Common themes among these recommendations are:

☐ improving employee recognition
☐ addressing stress due to workload
☐ improving communication and conflict resolution skills
☐ increasing employees' access to information
☐ increasing employees' ability to give and receive feedback
☐ exploring different shift schedules
☐ improving the relationship between workers and supervisors
☐ improving the safety of the working environment
☐ improving staff skills

The recommendations were linked when possible to existing structures, processes or initiatives. Experience has shown that recommendations which require the building of new entities are the least likely to be acted upon.

ONGOING COMMITMENT AND LEADERSHIP

The success of the committee relies heavily on the degree of continued support from senior management. Those committees that have the most support get the highest return on their surveys, are viewed by other staff in a positive manner, have senior management representation on their committee and have their recommendations viewed with interest and commitment to follow through. Other resources included meeting space and refreshments, small considerations, but ones which give the message that committee members' time is valued and that this is "real work." In their evaluation, committee members credited external facilitation as a key factor in maintaining their commitment to the project whilst being "snowed under" with other work.

The principles that support the Healthy Workplace process are key elements that give the process strength. These principles are not meant to be all inclusive; they are a sample of the fundamental ideas that guide the process. The process requires a healthy organization that:

- ☐ builds on existing strengths and strengthens the capacity of both individuals and groups
- ☐ encourages multi-sectoral participation and develops solutions with the people experiencing the issue
- ☐ respects the opinions of and values all participants
- ☐ enables people to take control of their own health
- ☐ challenges the status quo
- ☐ works with a long-term vision

A foundation principle of the Healthy Workplace process is that employees within the organization must own and direct the initiative. This principle is fulfilled through the creation of cross-sectional employee committees that guide and control Healthy Workplace activities for their worksite. The process is supported by third party facilitation and an all-inclusive employee survey that provides employees with the opportunity to voice their needs and register their concerns.

The process stages include the following steps:

- ☐ Commitment
- ☐ Issue Identification
- ☐ Healthy Workplace Profile and Plan
- ☐ Action Plan

The focus of the process is largely determined by the committee itself, what the hunches are around the nature of the gap between the preferred future and what exists now. Remarkable similarity has been found in peoples' visions of what a healthy workplace is, with differences in where they want to focus. That is the strength of having the type of tool that allows them to determine their own areas of inquiry.

EVALUATION

No formal evaluation of this process was done. This was the responsibility of the project manager. With the disbanding of the Population Resource Branch of the Ministry of Health, the provincial government's support for this project essentially ended.

The Population Resource Branch of the Ministry of Health did, however, contract an evaluation a couple of years ago. It mostly focused on the process rather than the outcomes.

LESSONS LEARNED

☐ **Successful projects must have the commitment and support of management.**

Senior management support can be shown in various ways. At one site, the administrator attended the first meeting of the committee, participated in the development of a vision, stayed in close contact with the committee throughout the process, sent them a congratulatory letter after their recommendations were submitted, and took the committee out for breakfast to review the recommendations and discuss implementation. This committee had no difficulty sustaining a positive attitude and high energy throughout the process.

In other committees management support was evident in the regular attendance and participation of members of the senior management team, in sponsoring lunch or breaks for committees and in the designation of a staff person as a resource to the committee.

One of the most essential ways that middle management supported these projects was in providing relief for committee members. On occasion this was an issue for a few committee members on two of the sites. In addition to providing relief, middle managers need to support staff in their role in this initiative. Requests for relief for one or two committee members at three of the sites were met with grumbling and complaining by their managers. Committee members who come to meetings with the support and commitment of their supervisors or managers are more likely to be able to sustain their energy through the project.

☐ **The process raises the hopes of staff for improvements in their workplace.**

The support of management goes beyond the process itself. The ultimate success of the project will depend on management's ability to follow through on the recommendations. All of the unions and the committees felt they "put their necks on the line" for this process, assuring co-workers that management would seriously consider their recommendations and make every effort to improve the health of the workplace. Even the perception of inaction on the part of management will not only seriously compromise the integrity of this project but could possibly diminish the receptiveness of employees to contribute to future initiatives.

It is of the utmost importance that management respond to the recommendations with vigour, involve employees in an immediate follow-up process, and widely communicate every action taken in the organization that is attributable or linked to these recommendations.

Past experience has shown that the period of time immediately following the feverish preparation of the recommendations is a difficult one for committees. Suddenly the work is over and people are tired. Commitment drops with the level of involvement. Committee members are vulnerable to considerable pressure from colleagues: they've promised results; where are they? Their personal reputations are on the line. The success of the project now rests wholly on the degree of priority that senior management places on the recommendations. It is important that site committees ensure that their members continue to be supported both individually and collectively and that their recommendations are (and are perceived by the staff to be) a high priority.

☐ **The committees need a range of resources to accomplish the process.**

The more support a committee receives, the better able they are to sustain their energy and produce high-quality outcomes. This is "real work" and must be treated as such. This not only means adequate backfill or support for meetings but also for committee members to implement communications, marketing and survey distribution plans. When these activities are relegated to an employee's "spare time" they don't receive the attention they deserve and the success of the project is compromised. Activities that need to be supported can range from preparing brochures to creating posters to stuffing envelopes. Building supported activity time into the project allowed some sites to better spread the workload among committee members.

Managers are typically not replaced for committee activities. Because they are perceived to have more control over their time and are frequently out of the direct patient care environment, they often are expected to take on many of the tasks that occur outside of the meetings. This process requires an enormous commitment of time on their behalf and that should be recognized and allowed for.

This project reaffirmed the importance of an external facilitator in maintaining the principles of workplace health promotion and ensuring that the committee moved through the process efficiently and effectively.

☐ **Trust takes a lot of time to build on these committees and is very fragile.**

At the start of the project, two sites struggled to gain support from one of their unions for the project. This initial struggle and the eventual achieving of support, though short-lived, was very intense and appeared to build a capacity for trust that was not as evident in the other two committees. Trust develops very slowly over time in these committees and depends as much on the willingness of members to contribute openly and honestly as the degree of safety provided by the facilitator. It is fueled by the sheer amount of time spent together by the same group of people; those committees whose members attended regularly had by far the highest level of trust. This was eloquently illustrated in one committee when a change in membership late in the process, compounded with irregular attendance, quickly eroded an already fragile trust.

☐ **Committees that spend more time together are more successful and resilient.**

In this project, the resiliency and success of individual committees was directly related to the amount of time they dedicated. The more they gave, the better able they were to sustain their energy and get the most out of the project. They created a sort of energy reserve that could be drawn on when the workload was high or the situation tense. There was more laughter, more teamwork and more commitment.

☐ **Survey results and follow-up data have to be very user-friendly.**

Although committee members felt that for the most part the appropriate information was collected, nearly all of them had some difficulty understanding the survey data. The experience of committee members in interpreting this type of data was very limited. Some of their requests for data involved three-way sorts that were difficult and confusing to understand. The presentation of the data could be improved by the provision of a carefully written interpretation of the data. In order to better assess the comprehension needs of the committee, it may be productive for the person(s) producing the data to spend some time with them. This was done at one committee meeting with excellent results.

☐ **The process has indirect personal benefits for committee members.**

The process was overwhelmingly a positive experience for most committee members. The benefits they described included:

- having a broader picture of the organization
- having an increased awareness of the roles of other departments
- having greater awareness of the problems and aspirations of fellow employees
- developing personal skills such as learning to respect the opinions of others
- experiencing team building and seeing its potential and advantages
- having the opportunity to contribute and practice speaking assertively

IN YOUR OPINION

I consider this model to be a success. Unfortunately, however, we no longer have a body capable of carrying out research to evaluate our model, so we will have great difficulty demonstrating our success.

My involvement with shaping the model was in re-shaping the principles and the process itself. The Merritt Group did the first reshaping of the process with the pilot groups other than hospitals and developed the survey tool. My involvement with this particular project ended with the completion of their recommendations/ action plan. We were also involved in the development of a course for Malaspina College to train facilitators in the process.

Some of the data collected is common to all four sites and should be further analyzed to identify trends and provide benchmarks for the project. At the very least, it would be important to compare results for different types of workers and to compare the long term care sector results across the sample. This information not only has implications for the Project but also to the health sector as a whole.

Once action plans were developed by senior management for each set of recommendations, the Pilot Project Working Committee needed to put a comprehensive evaluation plan into place. At a Project level, this evaluation plan should have reflected the trends identified across the sites as well as the original objectives. It should have specified reporting frameworks and prescribed a common evaluation model for each of the sites.

WORKPLACE WELLNESS: WELLNESS WORKS

Vancouver Hospital, British Columbia

INITIATIVE

The idea for the Workplace Wellness: Wellness Works program at Vancouver Hospital (VHHSC) was initiated in the spring of 1995 when a Wellness Program Steering Committee was developed. It consisted of hospital employees representing various departments and most unions in the organization.

LEADERSHIP

The Workplace Wellness Manager and her Wellness Team took responsibility for moving the process forward. The steering committee provided assistance with this initiative. The hospital management was very supportive, with the Vice-President of Human Resources championing the initiative.

NEEDS ASSESSMENT

In September 1995 an organization-wide needs assessment was carried out (over 5,000 surveys were circulated, over 1,000 returned). The information gathered from the needs assessment informed the team about the types of programs/sessions the staff would like to see offered, their self-reported level of well-being, and what benefits the staff expected to derive from a workplace wellness program. The programs implemented were based on these results.

Absenteeism at Vancouver Hospital was taken into account as an organizational need.

GOALS

The mission of the VHHSC Workplace Wellness program is to:

> *... promote individual and organizational well-being at Vancouver Hospital & Health Sciences Centre through initiatives which positively affect the workplace culture. To be a leader in workplace wellness through promotion of wellness both within and outside of our organization.*

The vision for the program was that VHHSC be a "well" organization with a workplace culture that understands, practices and supports the well-being of its employees and for "wellness" to be a commanding influence in the way VHHSC does business.

PROCESS

The processes used to implement the goals were quite complex as there were many ongoing initiatives. Firstly, from the Wellness Program steering committee, long-term subcommittees were formed to develop and implement programs by the year 2001 which addressed the key areas (career/life planning, humor, financial planning). On a corporate level, workshops which address stress management and time management were offered to all staff on a regular basis. A corporate-wide wellness incentive program, the "Wellness Challenge," was piloted in 1997 to increase awareness of wellness behaviours in employees. The initiative will likely become an annual program. The Wellness Team also organized monthly lunch-hour sessions which address various aspects of wellness. These sessions are facilitated by both internal and external consultants.

IMPLEMENTING THE GOALS, ADDRESSING THE NEEDS

To fulfill the goal of being a leader in Workplace Wellness, the Wellness Team at VHHSC hosts and organizes the annual national Health, Work, and Wellness Conference in Canada.

To assess the impact of wellness initiatives at organizational (absenteeism rates, long-term dollar savings) and individual (morale, work satisfaction, overall well-being) levels, the Wellness Team initiated a pilot project, the Wellness Promotion Research Project, which is currently underway in three hospital departments. This project is modeled after similar projects that have been conducted in the United States.

ONGOING COMMITMENT AND LEADERSHIP

The Workplace Wellness program has full support of the executive team at VHHSC and support from the middle managers. A growing number of staff are involved in the growth of the program.

In support of the Wellness Program, the organization provides financial support in the way of three employees who comprise the Wellness Team, and a small budget to operate the program.

MODEL/FRAMEWORK

The program development model followed the Value-Based Planning Model. The building blocks consisted of:

- ☐ Program Conception
  - review of current situation
  - formation of Steering Committee
- ☐ Needs Assessment
  - employee survey
  - health screening
  - assessment of organizational needs
- ☐ Planning/Goal Setting
  - resource organization
  - long-range plan based on needs assessment results
  - timelines
- ☐ Program Development
  - programs
  - tracking system
  - communications plan
  - policies
  - evaluation plan
- ☐ Program Implementation
  - programs
  - tracking systems
- ☐ Program Evaluation
  - evaluation of individual components
  - overall program evaluation
- ☐ Continuous Improvement
  - documentation of results
  - revisions/improvements to program

EVALUATION

A formal evaluation is being conducted on the wellness promotion pilot project which measures the impact of the Workplace Wellness Program on work satisfaction and attendance. Individual programs are evaluated as they are offered. The responses of the written evaluations are then used to further develop the programs.

IN YOUR OPINION

Based on our perceptions of the program, the process we have used to date has been successful in increasing awareness about organizational wellness. The results of our pilot project (available in 1999) will determine the success in terms of impact on work satisfaction and attendance.

This process has been molded as we have proceeded based on what works and what doesn't work in this workplace environment.

If we were to begin the process again the needs assessment would also assess the workplace culture, and we would work more closely with middle management from the beginning to determine their needs in order to change the corporate climate/ culture.

Individual Wellness Perspective

The Wellness Program has affected my workplace in several ways and I believe this is just the beginning.

It has opened my eyes to look for the positive aspects of the job as opposed to the negative. It has helped me get a clear perspective about my job and my responsibility to make the best of each day. I have become more aware of how to avoid difficult people and situations.

I have witnessed a noticeable change in the employee/ management relationship. It is evident to me that management, who at first seemed uninterested, have made an increasingly sincere commitment to the Wellness Program. This is apparent in their attitudes and treatment of the employees. Since my involvement in the Wellness Program I have experienced a considerable improvement in my health, in particular my mental health. I have reduced my use of sick days by a large margin.

I feel I have unconsciously absorbed a lot of education via workshops, meetings, etc. and much of this information has surfaced on a more conscious level. I have learned to reduce workplace stress and to utilize my remaining stress in a constructive rather than destructive fashion.

I refer to health in a broad sense, not entirely in the physical sense. Many of my illnesses in the past have been linked more to stress, anger and dissatisfaction than physical illness. Often, when I am physically ill, I can find a link to my mental health at that time.

The Wellness Program has also helped to improve my life outside of the workplace. My attitude has noticeably improved as I am much more aware of the impact of a positive rather than a negative outlook and reaction on situations beyond my immediate control.

The role I have played as coordinator has raised my self-esteem both at and outside of my workplace, which has caused me to take a long look at my lifestyle and to set goals to improve certain areas of my life.

My priorities have become clearer and easier to handle. I have become more interested in self help books, meditation and the power of positive thinking. I have increased my involvement with people and activities. I have also discovered that I actually spend time thinking about how I can help to improve situations that I may come across.

Continued.......

In general, the Wellness Program has given me a real sense of purpose. My self-control has increased, as has my esteem. I feel strongly that the Wellness Program is an asset to any workplace. I believe that, as it becomes more integrated throughout the establishment, as the awareness and understanding spread, the results will be not only economically beneficial, but the environment for staff, patients and visitors will be substantially improved.

Staff member
Vancouver Hospital
British Columbia

WORKPLACE HEALTH PROMOTION

Healthcare Benefit Trust, British Columbia

Employee Health & Safety Services began providing services to member organizations in 1993. The department provides an extensive set of programs and services toward the development of safe and healthy workplaces.

The mission is to actively work with employers, employees and unions to develop and implement effective programs that promote optimal health and safety. The mission os achieved through the provision of an extensive set of programs and services in the following key areas:

- ☐ Musculoskeletal injury prevention
- ☐ Occupational safety and hygiene
- ☐ Ergonomics
- ☐ Employee health and safety promotion
- ☐ Applied research and program evaluation

Specific services reflect the expressed needs of member organizations, and include consulting services, risk assessments and program reviews, program planning workshops, education and training seminars, claims management and attendance promotion, program evaluation and applied research. The department also develops resource materials, manuals and a newsletter, and provides a resource library where member organizations can borrow resources, video tapes, books and journals.

INITIATIVE

Health and safety are valuable resources within workplaces. They define the ability to fulfill goals, complete tasks and cope with an everchanging health care climate. The goal of a safe and healthy workplace is to create a supportive environment within the work setting that encourages safe, healthy and effective work for all. This environment, coupled with supportive organizational policies and procedures, is critical to helping people adopt and maintain safe and healthy work practices.

In turn, the personal distress and financial costs associated with absenteeism, illness, injury and disease are minimized, while the provision of quality health care is enhanced.

The dynamic nature of work in the health care industry demands creative approaches to promoting and developing employee health and safety in the workplace. Each workplace has its own unique culture, needs, goals, interests and resources, and any successful health and safety initiative must match this unique workplace profile.

LEADERSHIP

The Health & Safety Services Department was initiated by a new CEO in 1992.

It was thought that with the proper initiatives, the Trust and the health care industry in general could realize savings in the cost of benefits, particularly Long Term Disability costs. Employee Health & Safety Services works in concert with Rehabilitation Services to provide health and safety promotion, prevention, secondary prevention and early return to work initiatives as a continuum of services for member health care organizations. The leadership, therefore, is demonstrated by commitment at the highest level of the Trust. This commitment is further demonstrated by the support of the Board of Trustees, which oversees the policies of the Trust.

The current director of the department started with the Trust in 1993. Since that time, the Trust has continued to demonstrate its commitment to the programs and services by supporting the operations of the department, which includes six professional consultants and one support staff member.

The level of commitment and support among member organizations continues to grow as the model is promoted by the Trust. To date, approximately 60 percent of the member organizations have engaged in significant work with the Trust to establish health and safety initiatives in their work settings. The degree to which each is able to implement the initiatives depends heavily on the level of management commitment, as well as the resources that can be committed to such endeavors. There is confidence, however, that as the positive impact of this approach is demonstrated, there will be an increased commitment to developing workplace systems that promote and support health, safety and well-being.

NEEDS ASSESSMENT

The need to address health, safety and well-being in the health care industry was evident in a number of areas. The Trust was experiencing increased Long Term Disability claims, particularly those related to musculoskeletal injury. The WCB was also experiencing increased occupational injury claims related to musculoskeletal injury, and the health care industry had the dubious honour of ranking first in injury statistics in BC. Sick time utilization among health care workers was higher than national averages, and management exerted pressure on organized labour to establish health and safety as a priority in the workplace. As an industry, the needs were evident in both human and financial terms.

Following the establishment of Employee Health & Safety Services, the staff consulted with member organizations to determine the best approach to deal with increased injury, illness and disease among health care workers. This consultation included an understanding of each organization's needs. The ultimate goal was to establish workplaces that promoted and supported health, safety and well-being. This consultation process led to the establishment of a framework for the promotion of safe and healthy workplaces. The framework aims to stimulate positive change and create workplaces where the safe and healthy choice is the easiest choice to make for all employees. The wheels of change begin with actions that are catalysts for positive health and safety in the workplace. These actions allow the various stakeholders—employees and family members, employers, and unions—to influence positive change and create a safe and healthy workplace where employees have control over and can improve their health.

The framework was reasonably successful in creating understanding and stimulating activity in health and safety promotion. More successful, however, has been a model that presents the "spheres of influence," health, safety and well-being in the workplace.

In both cases the models, along with previous research results, helped to establish a common understanding and a starting point for gathering commitment and support to initiate health, safety and well-being programs and initiatives. In all cases, the Employee Health & Safety consultants from the Trust worked with organizations to establish a plan for the development and implementation of these initiatives. This included the articulation of a mission statement, the identification of key areas of emphasis, the development of goals within each area, and specific activities, work plans and required resources. The process was completed by gathering stakeholder representatives at each site to implement the plan.

Following a short iterative process the plan was presented to all employees at the workplace in the form of a needs assessment survey. The survey included gathering responses to the goals and activities of the plan and detailed information on employee perceptions of the workplace relating to health, safety and well-being.

GOALS

Employee Health & Safety Services has a mission to "actively work with employers, employees and unions to develop and implement effective programs that promote optimal workplace health and safety." The overarching goal is to "provide members of the Trust with leadership and solutions-oriented services that promote a commitment to a new organizational culture that results in safe work in a healthy place."

The process is implemented by member organizations following their request for assistance with health, safety and well-being initiatives, as described in more detail below. In general, however, organizations contact the Trust for assistance. They are asked to detail their current programs and initiatives through a self-directed outlined process which provides written information that sets the stage for establishing more detailed planning or other intervention(s). Part of this process is to determine the level of commitment and support, and to gain commitment from all stakeholders to proceed with the planning and needs assessment phases. In some instances the required intervention takes minimal planning while in others the planning process itself acts as the intervention.

PROCESS

The approach views program implementation as an ongoing activity which is expressed by the Implementation Cycle. This cycle is purposely developed with stop signs to suggest that people need to pause and take some action or perform some work at each step.

- ☐ **Commitment and Support**
  A positive statement of commitment and support is needed from all stakeholders. It means responding to health and safety in a cooperative fashion and making available sufficient resources. Key to developing commitment and support is a shared vision by administrators, supervisors, unions and employees. All stake-

holders must be involved in creating the vision, developing supportive policies and procedures, and promoting the concept among their constituents. Sufficient human, fiscal and material resources necessary to support the vision are the final expression of commitment and support.

☐ **Situational Analysis**
Ensuring the successful development of health and safety initiatives requires some groundwork and learning about the current health and safety situation. For example, collecting information on illness and injury rates, current costs of disability, employee health and safety needs, interests and expectations, risk factors including ergonomics and present health and safety policies and practices assists in defining the current health and safety situation and provides insight into program needs, resources and potential solutions.

☐ **Strategic Planning**
Strategic planning is the thoughtful process of combining the information from the situational analysis into priorities and action plans. Priorities are formalized as goals and objectives that specify health and safety change, how the change will be measured, the target group and a time frame. It is a basic requirement of strategic planning that all stakeholders are represented in the process. This means that management, unions, employees, and other internal and external resources are crucial participants.

☐ **Health and Safety Initiatives**
Initiatives are the specific activities designed to effect the health and safety changes identified in the goals and objectives. Initiatives are most successful when they present a healthy balance among individual, organizational and environmental changes. Typically, health and safety initiatives have focused extensively on the individual. Back care, stress management and smoking cessation programs are examples of individual initiatives. While individual initiatives are crucial to success in employee health and safety, they cannot be done at the exclusion of developing organizational systems and an environmental climate that supports the effort.

Smoking cessation programs offer a good illustration of the increased success of workplace health and safety promotion initiatives when addressed at all three levels. As individual programs, workplace smoking cessation classes have had limited impact on workers' smoking habits, and recidivism is high. Smoke-free organizational policy and support networks, in combination with cessation classes, have a much higher effect on smoking cessation among workers. When individual efforts are combined with organizational and environmental supports, safety and health outcomes are dramatically improved. It must be stated, however, that the consultation process attempts in all cases to assist members to find specific solutions to their health, safety and well-being needs. These programs and services vary to some degree as needs dictate.

☐ **Monitoring and Evaluation**

The implementation cycle includes mechanisms to periodically monitor the health and safety initiatives. Monitoring is the informal process of obtaining input and feedback from planners, providers and participants by asking "How are we doing?" Evaluation is the more formal, long-term assessment of the current situation, and the efficiency and effectiveness of health and safety initiatives. It requires the disciplined collection of health and safety information at strategic points in time. This information is valuable to decision makers at different stages in the implementation cycle. During the initial stages of obtaining commitment and support, and in the early planning and development, current situation assessment data is required. As health and safety initiatives are determined and implemented, process evaluation data is important. Finally, the maintenance or revamping of initiatives will profit from outcome evaluation results. Of course, the ongoing renewal of the implementation cycle means that the monitoring and evaluation phases and data collection will often overlap.

☐ **Maintenance**

A crucial step in the implementation cycle is a series of actions designed to ensure health and safety promotion grows as it matures and continues to challenge the workplace. This step focuses on the actions that are planned and implemented after the results are obtained from monitoring and evaluation efforts. These actions are designed to maintain commitment and sustain achievements, and may include new program development, recharging old programs, and commitment relapse prevention.

The ongoing renewal of the implementation cycle is key to all of these actions. Feedback from the evaluation of the health and safety initiatives provides the impetus for renewing commitment, reassessing the current situation, adopting the strategic plan, expanding initiatives, continually monitoring and evaluating progress, and maintaining positive achievements.

ONGOING COMMITMENT AND LEADERSHIP

Ongoing commitment and leadership varies depending upon which group is discussed. The Healthcare Benefit Trust is entirely committed to this process. As an organization it commits annual operating funds to support a department of seven staff including a full-time director, five consultants and one administrative assistant. Support is given at the highest level—the CEO and the Board of Trustees.

The consultation process provided by the Trust seeks to gain commitment and support throughout a member organization as an integral step in the implementation cycle. The degree to which an organization becomes ultimately committed varies depending upon a number of factors. Among these, the level of awareness and understanding of the value of workplace health promotion to the delivery of quality health care is key. Secondly, senior management in particular must be convinced of the business case for implementing workplace health promotion initiatives. In a time when resources and funding are being slashed, any initiative must be shown to have at least a cost-neutral effect on the bottom line.

Unions must be convinced that workplace health promotion initiatives are motivated by a concern for the health, safety and well-being of the worker. If workplace health promotion is seen to be a cost-cutting exercise only, unions are unlikely to support the effort. These various concerns and issues establish the probabilities for acceptance and success for workplace health promotion initiatives. Further, history plays an important part in the Trust's experience. If the organization has a track record of success in management/labour participation in new initiatives, health promotion efforts are usually more successful.

Finally, in these current times of health care reform, regionalization, downsizing and rationalization, many member organizations are dealing with issues that are either more important and/or more urgent. In the vernacular, some organizations have bigger fish to fry.

In any event, the degree to which Trust member organizations are committed to workplace health promotion initiatives depends heavily on the abovementioned issues. As might be expected, a wide variety of commitment to workplace health promotion among member organizations is experienced. Many are engaged fully in the implementation process and have a strong sense of ownership in the development of their workplace initiatives. Some have yet to even consider the model. Most are at stages in between having consulted with the Trust on various aspects of workplace health promotion, engaging in portions of the implementation process, and implementing various aspects of a plan. It is encouraging that a growing number of member organizations are devoting increased resources to workplace health, safety and well-being efforts, and an increased number of organizations want to utilize the Trust model and implementation process.

MODEL/FRAMEWORK

The process utilizes a planning approach to workplace health promotion initiative, development and implementation. The Trust believes strongly in the axiom "that the plan people build is the plan that they own and can therefore implement." Key stakeholders from throughout the organization are involved in a participatory effort to develop an organization-wide plan for workplace health promotion. The plan is developed following expressed commitment and support from management, unions and employees, and a clear understanding of the current situation with regard to health, safety and well-being in the workplace. The Trust assists by facilitating the process, providing technical expertise and resources, where required (e.g. conducting confidential employee surveys, interpreting results and making recommendations), and assisting in the development, implementation and evaluation of workplace initiatives.

The Trust's aim is to assist the organization to manage the process of health promotion in the workplace. Ultimately organizations should assume ownership for themselves and incorporate workplace health, safety and well-being into the culture as a way of "delivering health care services." Currently the focus is still on demonstrating the benefits of this cultural approach to the key stakeholders. Through the use of existing literature and "best practices" in this industry, awareness and understanding of the importance of health promotion in the workplace is raised. This effort has had positive effects, and interest and resources for workplace health promotion continue to grow.

The Trust believes that the nature of the implementation process allows for a comprehensive approach to workplace health promotion. Coupled with the Trust consultants' broad expertise in occupational health, safety and hygiene, health education, ergonomics and health promotion, the

Trust believes that it has assembled the appropriate mix of knowledge, skill and ability to implement the model, as well as complement the expertise that currently exists at many of the Trust member organizations.

EVALUATION

Over the past three years the Trust has worked with a number of member organizations to assist them in their efforts to create workplace environments that support health, safety and well-being. The results to date have been gratifying. Between 1993 and 1996 approximately 50% of the Trust's member organizations received services from Employee Health & Safety Services. These organizations showed significant improvement in absenteeism, WCB and LTD claims rates compared with those who did not utilize the services.

Specifically, Trust members who received EH&S services between 1993 and 1996 reduced absenteeism from approximately 13 days/FTE to 10 days/FTE, and the incidence of WCB claims by 10.9 percent as compared to non-service members who reduced claims by only 5.9 percent. The total reduction in serviced organizations was 437 claims, while non-serviced organizations reduced the number of claims by 86 for the same period. Similarly, LTD claims experience was on average higher for those that did not receive services compared to those that did. The group that did not receive services increased LTD claims by an average of 26 percent while the group that received services experienced an increase of only 12 percent, less than half the rate of increase of the non-serviced group.

What have these organizations done to make a difference? Based on work experience with various member organizations to date, the following factors stand out as key to improving health and safety performance:

☐ fostering commitment and support at all levels of the organization

☐ involving employees in planning, problem-solving and decision-making

☐ assessing the current situation and making decisions based on a thoughtful review of all individual, organizational and environmental factors

☐ focusing on prevention through increased awareness and educational efforts, risk assessments, and attention to safe work practices

☐ addressing individual and organizational values as they relate to creating a safe and healthy work environment for all concerned

It is recognized that each member's workplace culture is unique and that programs or interventions must be tailored to the particular circumstances or needs of that organization. There is no one program or service that makes the difference. Rather, it is a combination of factors that stem from a sincere commitment to the health, safety and well-being of all concerned within the organization. This commitment needs to be top down as well as bottom up. The middle ground is where all employees assume individual and collective responsibility for building healthy work environments.

In addition to the outcomes evaluated by the Trust, EH&S works with member organizations to evaluate the impact and outcomes of health promotion initiatives at their specific workplace. Typically, the evaluation process is integrated with the implementation process and assistance is provided in identifying methods to evaluate process, behavioural impact and longer term outcomes.

It is satisfying that the promotion and use of this model has stimulated activity among Trust member organizations, and that the activity has led to reductions in the costs associated with illness, injury and disease among health care workers. By comparing those organizations which have utilized the model with those that have not over the past three years, there are substantial differences in three outcome measures.

Continued efforts are necessary to promote utilization among organizations which are not following this, or a similar comprehensive approach to workplace health promotion.

WOW: WORKING ON WELLNESS PROGRAM

Sherbrooke Community Centre, Saskatchewan

INITIATIVE

Sherbrooke Community Centre is a long-term care facility serving 280 residents with 500 staff.

The idea for this process originated from staff members who were interested in improving their fitness levels. A committee was created in March 1997 consisting of representatives from various departments and members of the leadership team.

LEADERSHIP

The committee was chaired by a member of the leadership team. There was a high level of commitment and participation from the CEO and other management staff.

NEEDS ASSESSMENT

After a few meetings the committee realized that there were more issues of interest to staff than fitness alone. Information was received about the Corporate Health Model (Health Canada) and there was recognition that a needs assessment needed to be completed before delving into program planning.

A needs assessment was developed utilizing ideas from other surveys, as well as questions specifically designed for the workplace. The committee was very active in promoting the survey, and as a result achieved an excellent response rate of 73 percent.

GOALS

A subcommittee developed the following goals based on the results of the needs assessment:

- ☐ Help make Sherbrooke a fun place to work.
- ☐ Reduce absenteeism (sick time and WCB).
- ☐ Determine why individuals at Sherbrooke rate their health significantly lower than the national average.
- ☐ Support individuals in their efforts to exercise more.
- ☐ Support individuals in their efforts to eat healthier.
- ☐ Increase awareness of health issues (for example, smoking and pain management).

PROCESS

The committee plans to prioritize the goals and determine which ones will be focused on each year. Action plans are developed for each goal through committee brainstorming sessions based on the survey results and feedback from staff.

ONGOING COMMITMENT AND LEADERSHIP

Sherbrooke's leadership team is very committed to this project. The committee is expanding its membership to attain representation from every department/unit. The focus is on staff taking ownership of the process.

There is no financial backing at this time. There are resources available within Sherbrooke, as well as through affiliation with Saskatoon District Health.

MODEL/FRAMEWORK

Components of the Corporate Health model have been utilized mainly in terms of completing a needs assessment and a workplace profile. The same approach is used in developing any new program (developing goals and objectives, action plans and an evaluation system).

The process will be developed within the framework of Sherbrooke's CARE 2000 principles. The principles are continuous improvement, consultation/feedback, accountability, relevance, and empowerment.

The focus of the process is on creating a workplace that supports employees' individual efforts to improve their health. The process will become comprehensive, including all staff as well as creating a healthier setting in which staff can work.

EVALUATION

The survey will be completed again in one year and the committee will review any differences in results. Additionally, absenteeism and injury statistics will be compared to the statistics that were collected at the time the first survey was completed.

CAREGIVER PROGRAM

Casey House Hospice, Ontario

Casey House Hospice is a 24-hour facility, set up like a hospital. It houses 13 residential beds in 12 rooms, and includes a community program of 25 outpatients. There is a staff of 75.

INITIATIVE

The initiative for the caregiver program was established as a core benefit program when the Hospice was established in March 1988. The individuals involved in setting up the Hospice identified the need for a program of this nature. Initially the program emphasized emotional support for staff, but over time this has shifted into a broader understanding of wellness and general well-being. It is well documented that individuals working in hospices need additional support, so this initiative was incorporated at the very beginning.

LEADERSHIP

The Director of Nursing was responsible for the initial setup of the program. In 1991 this responsibility was transferred to the Director of Human Resources. There is an annual budget set aside each year for wellness initiatives. In addition, wellness initiatives were incorporated into the insured benefits package.

NEEDS ASSESSMENT

No formal needs assessment was conducted when the program was initially set up. Ongoing evaluation has taken place, which has helped shape the evolution of the program. After workshops, speakers, events and other programming, whomever is leading the event conducts an informal evaluation in which staff are asked for their feedback. Each year these evaluations are reviewed by the Director of Human Resources, and programs are modified accordingly.

GOALS

- ☐ Maintain solid, consistent staff. Keep staff turnover at an acceptable (low) level (5% or less per year).
- ☐ Reduce absenteeism.
- ☐ Maintain staff morale.
- ☐ Monitor long-term absences due to stress leave.
- ☐ Support staff when responding to patient complaints.

PROCESS

The programming at Casey House is offered on two levels: ongoing and regular wellness programs through the "Care for the Caregiver" program developed at Casey House, and individual or separate classes that are offered irregularly or at different times of the year. "Care for the Caregiver" provides occupational health services (contracted with another hospital) including first aid, health surveillance, primary medical care, massage therapy (subsidized treatment for full-time and part-time staff), personal days off (six per year for full-time staff), educational initiatives (including a bursary for ongoing continuing education and conference subsidies), prepaid leave plan (four-year salary spread over five), and employee assistance program (confidential service provided for staff, including resource referral). The individual classes offered depend on interest and demand among the staff, including yoga classes, seated massage therapy (once every two months), humour workshops, spirituality workshop/ discussion groups (six-week course offered once a year), and art therapy.

All wellness initiatives are evaluated and incorporated into the following year's plan. Participants are requested to complete an evaluation, as well as forward any ideas for future inservices.

ONGOING COMMITMENT AND LEADERSHIP

Management is fully supportive of the process.

Staff are fully supportive of the program; however, more non-clinical than clinical staff access the programs. This is partly due to shiftwork and difficulty accessing the programs.

MODEL/FRAMEWORK

There is no formal model or framework, but the following principles are employed:

- ☐ The wellness program comprises physical, spiritual, emotional and intellectual outlets.
- ☐ Staff are encouraged to recognize that caring for oneself is critical in hospice work and that it is their choice to participate in these initiatives.
- ☐ It is not the organization's responsibility to make the staff well but to provide the resources that can assist staff.

EVALUATION

The program is evaluated on an ongoing basis but is not tied to any indicators such as absenteeism, lost days or staff satisfaction. It is weak in this area.

This model is successful because the programming takes a holistic perspective of the person.

The Director of Human Resources is responsible for the program and the Pastoral Counselor is the staff resource person. They are involved in the planning and running of the program.

Some of the challenges faced are:

- ☐ getting staff to understand that they must take responsibility for their health—it is not the organization's responsibility
- ☐ funding
- ☐ determining whether programs should be run on-site or off-site
- ☐ expectation of staff that they should be paid to attend specific programs (grief and bereavement workshops)
- ☐ generating new ideas for programs

SHIFTWORK & COMMUNITY NEEDS

CASE STUDIES

SHIFTING TO WELLNESS: HEALTHY SHIFTWORK
Keyano College Lifestyle Services, Alberta

SHIFTING TO WELLNESS
Aspen Regional Health Authority, Alberta

FITNESS & LIFESTYLE PROGRAM
RCMP Health Services, Alberta

SHIFTING TO WELLNESS: HEALTHY SHIFTWORK LIFESTYLE INITIATIVE

Keyano College Lifestyle Services, Alberta

INITIATIVE

Shifting to Wellness continues to be recognized as a credible health education tool for shiftworkers and their families. Keyano College Lifestyle Services (KCLS) has grown to be recognized as a shiftwork health education resource centre, delivering shiftwork health education and promotion throughout Alberta and North America. This is due in part to funding made available through the Employee Leisure Lifestyle Development Grant provided by the Alberta Sports, Recreation, Parks and Wildlife Foundation.

As we live in a society of global competition and communication, there is a growing number of shiftworkers in both traditional and non-traditional sectors. This initiative addresses the health needs of those working all varieties of shiftwork. It is a tool to build self-healthcare and self-reliance into the workplace environment.

Keyano College Lifestyle Services' (KCLS) role in Shifting to Wellness has grown over the years to position itself as the leader in training and resource development in Alberta.

LEADERSHIP

In 1992 it was determined, through a series of meetings between industry, schools and community representatives, that very few people in Fort McMurray and the region of Northeastern Alberta were aware of shiftwork health-related research. Concurrently and separately from these meetings, a division of a local mining corporation was independently contracting a company from Portland, Maine, to provide shiftwork assessment and associated lifestyle education. Through attending one of the on-site training sessions, KCLS realized the wealth of information that was available and critical to the health of the region. In response to this identified need, a funding partnership was formed in the fall of 1992 between the Fort McMurray and District Health Unit and KCLS. The bringing together of dollars allowed work to proceed specific to shiftworkers' heart health and shiftwork healthy active living. Alberta Health provided the Health Unit dollars; Alberta Recreation Parks and Wildlife Foundation/Alberta Lottery dollars provided project funds to KCLS. Through this dual partnership, a community/schools/industry advisory committee was created.

Commencing with the establishment of critical goals and objectives, this committee proceeded to support pertinent research and information gathering: the development, printing and distribution of resources, the hiring of a project coordinator, shiftwork health education broadcasting on local television and radio, interactive displays at schools, industrial sites and local malls, and school visitations and interviews with shiftworking family members to identify local lifestyle issues.

Notably, in 1994, a full-colour soft-cover publication was produced containing stories of local residents who worked extended hours in different professions and roles, including parenting. The book highlighted problems and practical solutions. This publication proved to be a valuable introduction to what was soon to follow.

ONGOING COMMITMENT AND LEADERSHIP

By 1995 KCLS was very busy managing initiatives developed through department and advisory committee involvement. Employee Leisure Lifestyle Project grant dollars from the Alberta Sport, Recreation, Parks and Wildlife Foundation continued to support the overall approach of regional shiftwork health education. Courses and training opportunities were being offered to the public and private sectors. Keyano College, being a community college, provided an ideal location for centralizing a growing data bank of information, contacts and teaching resources.

During this time KCLS received a request from a regional oilsands mining division. Eighteen hundred employees and spouses were to attend three hour shiftwork health education sessions over a period of one month. Each attendee was to receive a personal guide book for Shifting To Wellness. The series of sessions were to be taught by industry-selected mining employees. KCLS was asked to be a consultant to the process, providing the initial training for the presenters and customized education resources throughout. KCLS met the challenge.

The group of mining personnel chosen to instruct attended a week-long training session at Keyano College. The teaching materials included the KCLS Shifting To Wellness trainer's manual. The second part of the course was provided by the mining corporation and concentrated on public presentation. The Shifting To Wellness guide book was published by KCLS and distributed to shiftworkers and their spouses at the education sessions for ongoing self-health development. Additional copies of the guide and introductory booklet were purchased for on-site and community use.

This past year of 1997 has really given Shifting to Wellness the boost to be used and promoted in various parts of Canada and the US:

☐ In July 1995, an article published in the National Wellness Institute's (Steven's Point, Wisconsin) newsletter entitled "Wellness Management" opened a number of doors for Shifting to Wellness.

☐ Resulting from this one article were numerous requests for materials, training and presentations at various conferences.

☐ In January 1997 a request came from the RCMP K Division in Edmonton for Shifting to Wellness materials and training. Training was held in mid-May and K Division is actively planning a STW pilot project in Alberta before taking the program national. To date, all RCMP divisions in the country have purchased at least one set of materials.

☐ In May 1997, previous to the RCMP training, Shifting to Wellness was presented at the HPEC/CAPHERD Conference in Red Deer, Alberta.

☐ In June 1997 NAV Canada, a division of Transport Canada responsible for Air Traffic Controllers throughout the country, purchased training materials currently under review before deciding on a project.

☐ In July 1997 Shifting to Wellness was presented at a one-day pre-conference seminar at the 22nd Annual National Wellness Conference in Steven's Point, Wisconsin. Their experience with using a peer-led approach to training in the workplace was shared at a breakout session.

☐ Over the past year more than 100 introduction packages have been sold, along with numerous support materials. Revenue is also generated with contracts for STW training in the worksite.

Within the Regional Municipality of Wood Buffalo, a few separate shiftwork education initiative s are presently taking place through workplace wellness programs and employee assistance centres. They provide strength to each other and to the entire Shifting to Wellness movement.

During August 1997 a course was offered to train all Be Fit For Life Center Coordinators and staff with the Shifting to Wellness materials. This allowed for an increase in qualified trainers, and ensured that all areas of Alberta have a Shifting To Wellness trainer close by.

Many marketing steps are utilized to reach prospective clients. Advertising is a major component, including newspaper ads, magazine submissions, television interviews, and radio ads. KCLS also presented at conferences such as the First Annual Health, Work, and Wellness '97 Conference in Vancouver. The response from this national conference has been outstanding, with interest across Canada. They are currently developing a web site for easy access and have discovered that their program is also mentioned on other web sites.

KCLS encourages the program to be received in the company through peer-led training. A Train the Trainer seminar is given and the company will then establish its own branch of Shifting To Wellness with trainers on site. New employees, or those who need to discuss shiftwork issues, have a knowledgeable coworker to turn to. The other option is to have a presentation given directly to the shiftworkers or management. The trainer receives a user Leader Binder in which he/she can follow along and keep it as a reference. Both books are illustrated with original artwork that depicts a variety of people with different ethnic backgrounds, ages, and genders.

Frequently an interest group will ask for specific information regarding only one aspect of shiftwork demands, e.g. shiftwork and sleep disruption. From the massive amount of research material collected, this request is easily met. The Shifting to Wellness material is also often bought by individual workers for personal use. They do not require training, but instead wish to be updated with new health information that can be shared with the family. KCLS encourages full family participation with shiftwork concerns, because the stress and daily demand extend far beyond the company walls.

EVALUATION

The evaluation process to date has been rather slow. Initially, this vital component of a wellness program was neglected, but an evaluation tool is currently being developed. KCLS has survey forms for the shiftworkers prior to training, and again six months after training, to compare findings.

Questionnaires are also sent to:
- ☐ company management
- ☐ trainers
- ☐ Be Fit For Life Centre Trainers
- ☐ family members

Management has informed KCLS that the program has been effective in increasing employee morale by raising awareness of the demanding issues involved with shiftwork. Decreased absenteeism and decreased error on the job have also been noted. Of course this is encouraging, but statistical information compiled by the return of a practical evaluation tool would be preferable.

IN YOUR OPINION

Based on my perceptions of the program, I certainly consider Shifting to Wellness to be a success. Positive feedback encourages our program to strive for excellence. As I am constantly aiming to improve and move forward with current information, I have compiled a current literature search and include copies with each order. I will soon begin to create the second edition of the resource material with the most current information. It is crucial to include new ideas, and eliminate those that are outdated.

The audience direction is changing from the initial oilsands interest to companies of all sorts. Any work done outside the hours of 8:00 am to 9:00 pm is included in the shiftwork definition. We have provided shiftwork management information to police officers, limestone quarry miners, paramedics, nurses, occupational therapists, truck drivers, laborers, security officers, custodial staff, correction/ parole officers, gas station attendants, trades students, railway workers, newspaper printers, and phone companies.

The Shifting to Wellness initiative is still in its early years of development. If the program was starting again, I would encourage communication with similar programs to inquire into their original roadblocks and stumbling stones. It is easiest to overcome problems if they are anticipated, as opposed to being surprised!

I am very happy with the commitment of our trainers, and the energy that they provide when conducting seminars. Interested companies have responded positively to our initiative, and keep in touch to receive new information, or simply to talk about how pleased they are to have received training. Shiftwork is a hot topic, and I encourage all companies to implement shiftwork awareness strategies with their workplace wellness programs.

SHIFTING TO WELLNESS

Aspen Regional Health Authority, Alberta

THE ASPEN REGION

- ☐ The Aspen Regional Health Authority #11 is located in the center of the Province of Alberta and encompasses 33,149 square kilometers.
- ☐ The region boundaries cover the areas from Calling Lake in the northeast, to Fox Creek in the northwest, to Morinville in the south, to Onoway in the southwest. The Aspen Region boundary meets the City of Edmonton and St. Albert to the south. Aspen includes Canadian Forces Base Namao, and the First Nation reserves of Alexander, Alexis and Jean Baptiste Gambler.
- ☐ There are 47 communities of various sizes from hamlets and towns to summer villages in the Aspen Region
- ☐ The Aspen Region is primarily based on agriculture and ranching. The northwest and northeast area of the Region is resource-based with oil and gas, and forestry pulp and paper industries.

DEMOGRAPHIC INFORMATION

- ☐ Aspen Region has 81,076 permanent residents.
- ☐ With six provincial parks and 22 summer villages, the population of the Region increases significantly during the summer season.
- ☐ The southern/southeastern area of the Region contains the highest concentration of population, within commuting distance of the metropolitan areas of Edmonton and St. Albert.
- ☐ The agricultural area in the central and southeastern portion of the Region has a large percentage of seniors.
- ☐ The communities to the northeast and northwest have an average age of less than 30 years.
- ☐ "Non-traditional" working hours are a fact of life. Currently more than half the labour force work night shifts, extended hours, split shifts, on-call, on rotation, or they have commuting requirements that extend the workday. There are impacts to these irregular working hours. The demands on the body clock require resilience

and an ability to adapt. Nutrition, exercise, sleep patterns, relaxation and recreation, and healthy relationships are all components of building resilience and promoting a healthy lifestyle. Distress in any one of these areas affects the whole person, and has a negative impact on personal and family health and relationships.

INITIATIVE

Aspen Health Services is committed to supporting health by sponsoring a program developed by Keyano College in Fort McMurray. Shifting to Wellness is based on current recommendations from research, combined with practical solutions aimed at achieving wellness. It is geared to shift workers and "shifting to wellness."

In 1995 the delivery of health care in Alberta underwent a radical restructuring where over 300 hospital boards, public health units, long term care boards and facilities were joined together under 17 Regional Health Authorities.

As a result of this amalgamation, Aspen Regional Health Authority's various programs and initiatives were rationalized and regionalized. Through this process, an in-depth study of the 47 communities was undertaken. The study looked at the demographics of the communities, the key economic engines, various reports on file and an analysis of issues/challenges facing the various communities. A number of the communities' primary economic engines are centered around forestry, pulp and paper, and oil and gas industries. One community had just completed a community-wide capacity study which identified a number of stresses affecting the community, with a number being attributed to shiftwork schedules. A separate study showed that this community was also home to a significant number of single-parent households led by men. Further analysis of the resource based communities showed that nearly 50 percent of the population were shiftworkers or were part of shiftworking families.

Aspen Regional Healthy Authority decided to tackle the problems arising from shiftwork.

Goals for the project were defined and a proposal was presented to Aspen's Action For Health Steering Committee, which enthusiastically supported initiating this program for the Region.

LEADERSHIP

A Coordinator initiated the project and had a vital leadership role in gaining approvals and funding through the Action for Health grant program offered by Alberta Health. Once funding was in place a team leader was employed. Lesson plans, course materials, overheads, group activities, workshop outlines and evaluation tools were further developed. A corporate partnership program and a marketing strategy were designed.

NEEDS ASSESSMENT

Needs were identified through researching and collating information about the communities of Aspen rRegion. These studies helped to develop a "snapshot" of each community, including demographic information, Alberta Health statistics and community reports. The community of Whitecourt had recently completed an in-depth capacity study which clearly indicated a number of stresses in the community that were attributed to shiftwork.

The results of these studies led the health promotion team leader to search out approaches, programs and ideas that existed to address these concerns in other communities. Various programs were reviewed and the Shifting to Wellness program developed by Keyano College in Fort McMurray was felt to best meet Aspen's approach to working with the community. Understanding the components, objectives and the delivery model for the Shifting to Wellness program in Fort McMurray helped the Aspen Health Promotion Team define the approach it would take in the Aspen Region.

GOALS

Goals for Year One - 1996-1997

- ☐ Increase wellness for shiftworking employees and their families through providing opportunities to learn about the impacts of shiftwork and coping strategies and lifestyle choices that can reduce these impacts.
- ☐ Increase awareness with employers in the Aspen Health Services Region about the added stresses shiftwork can have on employee wellness, family and relationships.

☐ Partner with two major employers in the Aspen Health Services Region to deliver the Shifting to Wellness program for employees and their families.

☐ Partner with agencies/organizations in the region to deliver information sessions for small business about the Shifting into Wellness program (Family and Community Support Services, Chamber of Commerce, Economic Development Boards, Business Development Centre, healthcare professionals, wellness/fitness workers).

☐ Train six to eight "wellness" advocates (trainers) to work with co-workers within companies in the Region.

☐ Develop a network with business to sponsor and distribute Shifting to Wellness monographs as a regular communication tool with employees and their families.

☐ Deliver Train the Trainer session: 1996-1997.

☐ Deliver eight to ten Shifting to Wellness information sessions (two to three hours) throughout the Aspen Health Service Region.

Goals for Year Two - 1997-1988

☐ Deliver eight to ten Shifting to Wellness information sessions (two to three hours) throughout the Aspen Health Service Region.

☐ Deliver four to six Shifting to Wellness community information sessions (two to three hours) throughout the Aspen Health Service Region.

☐ Deliver two Shifting to Wellness five-day Train the Trainer Workshops; one within the Aspen Region and one for Aspen employees and other Regional Health Authority staff.

☐ Continue the partnership with community newspapers for the printing of the monthly Shifting to Wellness advertorials.

☐ Update Shifting to Wellness materials, coping flyers and lesson plans, and maintain the reference database with current articles, stories and citations about shiftwork.

☐ Develop a Shifting to Wellness management workshop for delivery in early 1998.

☐ Complete six-month and twelve-month follow-up evaluations with Shifting to Wellness trainers to measure progress and use of the knowledge gained.

PROCESS

Various programs that are aimed at shiftworkers and workplace wellness were reviewed. Initially Aspen linked up with Keyano College in Fort McMurray. In partnership with Syncrude Canada, Keyano College had developed and implemented an holistic program that addressed the wellness issues Aspen felt were important. Two trainers were oriented to the basic elements of Keyano College's Shifting to Wellness program in February 1996.

The program was revised for delivery as a five-day Train the Trainer program. Materials were developed including handouts, overheads, group exercises, a pre-test and post-training evaluations.

The leaders' guides were updated and considerable time was spent in augmenting the basic information in the guide. In some topic areas the whole section was rewritten. Lesson plans, course outlines and handout materials were designed and produced. Coping monograms and articles were written, edited, and printed. Research was conducted through literature reviews and internet studies to keep up to date with the latest developments. A five-day Train the Trainer course was developed.

A corporate partnership proposal was developed. An analysis of the Region's employers that hire shiftworkers was completed.

A targeted marketing program was initiated, with letters sent and follow-up phone calls to all businesses employing over 50 employees.

Local major industries were approached in April 1996 and offered the opportunity to partner. Companies including Millar Western Pulp, Alberta Newsprint Company, Blue Ridge Lumber, ALPAC (Alberta Pacific), Tawatinaw Business Development Corporation and Pembina Regional School Division were excited at the prospect of improving the health of their workers and employees and agreed to become partners in the delivery of the Shifting to Wellness program.

Two five-day Train the Trainer Workshops were delivered, one held June 1996 and the second November 1997. Participants from the following companies and organizations attended:

- Blue Ridge Lumber
- ALPAC
- Tawatinaw Business Development Corporation
- Whitecourt Medicine Bottle
- Westlock Recreation

- Westlock Long Term Care
- Aspen Health Services
- Alberta Newsprint Corporation
- Millar Western - Pulp
- Caritas Health Care (Edmonton)
- Pembina Hills Regional School Division
- Communicating Power Inc.

In April 1997 the Aspen Health Promotion team hosted a mini Train the Trainer session for the Employee Assistance Program Committee with Pembina Hills Regional Division. This session was also well received.

In June 1997 the Shifting to Wellness trainers at Millar Western hosted a one-day Shifting to Wellness Workshop for their peers in which a total of 125 out of 141 staff participated (or 89 percent). They organized the sessions and presented selected sections of the day.

Additional plans for supporting the work of the newly graduated trainers were set in place. The program was augmented by a news article program. One article per month is printed in local weekly/monthly newspapers in the Region featuring a topic about shiftwork.

ONGOING COMMITMENT AND LEADERSHIP

The Aspen Regional Health Authority Board and Senior Management Team continue to support the Shifting to Wellness program. A program leader is in place. Other members of the health promotion team are trainers and provide support for training and promotion of the program.

A specific workshop for management is under development for delivery in 1998.

Aspen Region has just completed its own Employee Wellness Survey. Preliminary results indicate that many aspects of the Shifting to Wellness program will match identified areas of need. Workshops and one-day wellness fairs are planned for 1998 throughout the Region.

The partnership with local newspaper publishers has been renegotiated for a further six-month period. Shifting to Wellness news articles appear monthly in all major local weekly and monthly newspapers in the Region.

Aspen Health Services has committed $20,000 in staff time and resources for Year Two of the Shifting to Wellness program.

Corporate partners have shown a very strong commitment to the program. Each company has taken ownership of the Shifting to Wellness program and has customized the delivery for their needs. Financial commitments by corporate partners range from $10,000 to $45,000 in the first year of the program.

The corporate trainers have stated that non-shiftworking managers require a better awareness of the impacts of shiftwork to address workplace issues. Aspen is currently planning a workshop geared to the needs of managers to share some of the challenges and coping strategies that can reduce the impact of shiftwork for workers, their families, the company and ultimately the community.

Keyano College continues to support the program and has agreed to complete a literature search annually. The results are reviewed and a synopsis is prepared for distribution to Aspen trainers.

MODEL/FRAMEWORK

The principles of the model are:

- ☐ Aspen will take a leadership role in increasing awareness about shiftwork the factors that impact on the health of workers and their families.
- ☐ Businesses will take responsibility for their employees and community by working with employees to improve workplace wellness.
- ☐ Individuals are responsible for the lifestyle choices they make, that practical strategies can help people cope with the added stresses of shiftwork, and a positive supportive work environment will contribute to their well-being.
- ☐ Peers are the best trainers—they live the talk every day!
- ☐ Aspen can act as an advocate in the community for workplace wellness programs.
- ☐ Aspen has a responsibility to work with employers in a cooperative manner and to work in partnerships where win/win scenarios are achieved for all partners.

☐ Workshops offered by Aspen must be well planned, with professional materials utilized, quality delivery, and provision for participants' interaction throughout the process, creating a great learning environment.

☐ The Shifting to Wellness program will be evaluated by an outside consultant and quality evaluation tools will be administered throughout the program.

The Focus of the Model is to:

☐ Create awareness about the impact of shiftwork.

☐ Assist companies and workers in learning strategies and lifestyle choices that can improve wellness for workers and their families.

The Model Itself

Keyano College has created an excellent framework which Aspen customized and expanded to meet the needs in their communities. This process is a very effective and well developed model. Corporate partners used the model in delivering their own aspects of the Shifting to Wellness program.

Throughout the program the integrity of the Shifting to Wellness message has remained paramount in program enhancements, delivery and materials. The holistic approach is vital to the delivery and acceptance of the program. All aspects of the program withstood vigorous testing with shiftworkers as they became trainers and delivered training within their companies.

EVALUATION

The evaluation component was integral to the program. A clear goal up front for Aspen was to ensure that evaluation of the program was appropriate and accurate. A consultant specializing in evaluation was hired to assist the project team in developing appropriate tools and methods to evaluate the program. Further, the consultant analyzed all the completed evaluations and reports and prepared summaries for Aspen management.

A pre-test was developed to assess knowledge base and experience level with shiftwork issues. The pre-test was sent to all participants prior to the five-day Train the Trainer Workshops. The pre-test asked various questions about the impact of shiftwork, chronobiology, eating and sleep habits and shift schedule design. The pre-test was also used as a teaser to get people to think about their role in taking the five-day Train the Trainer Workshop.

Throughout the training sessions coping strategies identified in the workshop were diarized for development into monographs and resource materials.

A course evaluation was completed by participants at the end of the workshop. The last afternoon was spent in planning strategies for sharing the information with co-workers, family and the community.

A six-month follow-up evaluation was sent out to all participants to measure what actions trainers had taken and what further support was needed.

The evaluation process was an effective tool in analyzing whether or not an impact had been made with the participants. Many of the coping strategies learned by participants were having a significant positive impact on shiftworkers, their families and their companies. The evaluation process also identified where gaps in communication were occurring in various companies and at times within a community. Aspen was able to address some external issues through other avenues and connections in the communities.

The evaluations showed how critical it was for Aspen to maintain a support network for the trainers to aid them as they moved forward with their initiatives within their companies and communities.

The impact of this initiative has been significant.

Highlights of the Implementation Process and the Process of Creating Supportive Healthy Environments

- ☐ Through employee initiative, shift schedules have been reviewed and approvals for improving design are underway.
- ☐ One employer has included a one-day "shiftwork" awareness workshop in its summer student program.
- ☐ A one-day Shifting to Wellness workshop has become a required part of the company's orientation program.

☐ Participants in the Train the Trainer Workshop have a much better understanding of the impact of shiftwork on their shiftworking coworkers and act as "expert resource " people on their shifts.

☐ In one company, the human resources staff have altered their service hours to better serve the needs of their shiftworking peers. Outgoing calls are not made to shiftworkers until 3 p.m. in an effort to demonstrate awareness that night workers need to get their undisturbed sleep during normal daylight hours.

☐ In one community, rehabilitation providers will not book appointments with shiftworkers until after 2 p.m.—knowing that shiftworkers require their sleep.

☐ Workers in one company "dissected" and revamped vending machines in the company cafeteria to offer at least 50 percent healthier choices, like fruit, fruit juices, and lower-fat snacks. Coffee machines now have a pot of decaffeinated on tap at all times.

☐ Upon completion of the Train the Trainer Workshop, one company's Shifting to Wellness trainers took a leadership role in developing and undertaking an employee wellness survey. An analysis of the survey was completed and a customized Wellness program is now under development to address highest priority issues first. Aspen has been invited to work with the team in providing resources for delivery of some of the components of the program.

☐ Employees are investigating ways to improve their workspace, including lighting, furniture and decor.

☐ Simple techniques are being employed to improve alertness: workers are taking stairs more often, taking the long way around the plant floor, getting up and stretching when they feel drowsy, asking for help from other workers, sharing recipes and strategies with each other, and generally enjoying the fun of shiftwork as a team.

Our Success is Showing...

The most significant indicators that the Shifting to Wellness program is a success are the written comments on evaluations. A sampling follows.

☐ "I was ready to quit working shift though I know it would have a negative impact on my family's financial status... I now feel that I can continue to work shiftwork by using some of these new strategies. Thank you."

- ☐ "My family now values sleep and its importance... we have tried to arrange our lifestyle to ensure we get adequate sleep and don't feel guilty about it!"
- ☐ "This is the best course I have attended... the trainers were just excellent - they were professional, very well prepared and they really cared about us, how we felt and they listened to us - they acknowledged our expertise as shift workers and helped us build confidence in our skills and knowledge. I sure hope the company paid you guys a lot of money for this week!"
- ☐ "I now know that there are reasons why I have been so grumpy and hard to live with - my wife and I have discussed how my shiftwork has impacted our relationship. We now have fun blaming shiftwork instead of each other for grumpier moments."
- ☐ "I thought I was the only one who felt so awful on night shift - only to find that my co-workers were feeling equally as lousy especially at 4 in the morning. We are now working on ways to support each other through the really tough spots in the wee hours."
- ☐ "I can't believe how these simple strategies have improved my sense of wellness. I only wish I'd known about these (strategies) when I started working shift 20 years ago."
- ☐ "Starting my own business I find it hard to balance all the demands - but I know how important sleep and proper eating are to help me cope better."

IN YOUR OPINION

The model of peer training was extremely effective in this project. The evaluations clearly indicated that people had made clear changes in their lifestyles that helped reduce the impact of shiftwork. This was particularly evident in the six-month follow-ups where lifestyle changes were being made —some as simple as a change in attitude, to understanding the physical impacts of shiftwork and taking steps to create healthier coping strategies, better family communications and taking better care of oneself.

The Shifting to Wellness trainers are the best advertising. The program participants are sharing their successes with friends and family and much interest has been created in other companies and communities throughout the Aspen Region. Millar Western of Meadow Lake, Saskatchewan, has committed to delivering the program for their workers. There has been interest from other health regions to receive more information and we have received requests to hold more Train-the-Trainer sessions in other communities.

The model allowed greater flexibility in delivery within the various companies. Each company encouraged the Shifting to Wellness trainers working together as a team to define and deliver the program they believed best suited their individual corporate cultures and operations. All the corporate partner companies have contributed in a real financial sense—as all trainers' time, materials, meals and allowances were paid, as well as time to plan, develop and deliver various aspects of the Shifting To Wellness program. One company has in fact provided paid time for all their employees to attend a one-day Shifting to Wellness workshop on-site. This company's direct costs calculate to over $45,000.

The program coordinators had a significant role in shaping the model. The initial training team's approach, exercises and materials were planned to be interactive and to support group discussion. Capacity building strategies were used to "bring out" the unique talents in the group. Participants' personal experiences were given acknowledgment throughout the workshop. Aspen was very clear that our trainers were not the experts—that shiftworkers themselves can reduce the impact of shiftwork through sharing coping strategies and healthy lifestyle choices. Also, as stated earlier, each company has implemented the program to reflect the needs and strengths of their own organizations.

Continued.....

The Shifting to Wellness program coordinator provides support to the trainers and companies. Consulting support was provided in planning training, assisting with on-site training and co-ordination, but clearly the trainers took the lead role in defining how the program was to be implemented in their company. We provided resources and cheered them onwards!

Aspen also provides an ongoing public awareness campaign through a monthly Shifting To Wellness editorial in all community newspapers. Displays are under development for community trade fairs.

Any company, employer or organization in the Aspen region has access to the program and materials.

The following companies are using the program:

- *Millar Western Pulp*
- *Alberta Newsprint Corporation*
- *Blue Ridge Lumber*
- *Pembina Hills Regional School Division*

FITNESS & LIFESTYLE PROGRAM

RCMP Health Services, Alberta

INITIATIVE

The idea for this project was initiated in Ottawa through the Health Services Directorate. Each Ddvision (province) of the RCMP has a Health Services Branch which operates primarily with a physician, an occupational health nurse, a psychologist and an occupational health and safety officer. The RCMP, unlike any other organization, does not operate under the *Canada Health Act*. The Health Services Branch takes financial responsibility for all medical requirements for RCMP members and their families by paying for and controlling all medical accounts to outside agencies.

The Health Services Directorate initiated a Wellness process when they sent out a Health Promotion Survey in 1985. From that survey RCMP employees specified that they believe there should be additional support provided to them through the Health Services Branch in the way of fitness and lifestyle.

Each RCMP member is required to complete various tasks for physical requirements for police-specific work. As part of their periodic medical, there is an occupational evaluation called the Physical Ability Readiness Evaluation (PARE). This section of their medical was introduced to members of the RCMP in 1991. Due to the nature of this evaluation, and the results from the Health Promotion Survey, the RCMP decided that members would require professional advice in the area of physical fitness in order to pass the PARE.

LEADERSHIP

As mentioned, the Health Services Directorate was responsible for initiating this program. The Chief of Fitness & Lifestyle for the RCMP started this Wellness initiative by hiring a fitness professional in each of the Divisions as a Division Fitness and Lifestyle Advisor (DFLA). The organization provided funding through Ottawa to pilot the Fitness & Lifestyle program nationally. At the present time, the level of commitment for the program varies from division to division. Each

DFLA is responsible for determining the needs of his/her division, developing, implementing and evaluating a Fitness & Lifestyle Program.

NEEDS ASSESSMENT

The Health Promotion Survey in 1985 was sent out to a random sample of RCMP officers throughout the country. This survey was used to develop the model for the project itself. In addition, each DFLA has also utilized this information to determine a starting point for the specific needs of their Division.

In "K" Division an informal needs assessment was performed by visiting detachments and informally collecting information regarding specific fitness and lifestyle needs. Some surveys were distributed specific to these predetermined needs to determine the role of the Fitness & Lifestyle Section.

The outcome of the needs assessment basically specified that members require information and training in the areas of fitness, equipment purchases for their specific detachments, nutrition advice, exercise rehabilitation programs, back care advice, shiftwork programs and assistance with preparing for the PARE. This information has helped to determine a base for developing specific programs.

GOALS

Some of the goals specified were:

- ☐ Set up a number of PARE test sites throughout Alberta and the NWT so that members had better access to practicing and performing the PARE as part of their periodic medical. This required equipment acquisition, setup, training and certifying individuals to administer the PARE.
- ☐ Train regular members in the field as Detachment Fitness Coordinators. These members have been certified through the Alberta Fitness Leadership Certification Association to assist members with strength and conditioning programs. In addition, they have been certified through the Canadian Society of Exercise Physiologists (CSEP) as Certified Fitness Consultants to administer the Canadian Physical Activity Fitness and Lifestyle Assessment (CPAFLA). The members are better served with a more hands-on approach.

- ☐ Work with the Health Services Branch as part of a team of professionals on case management.
- ☐ Develop and deliver nutrition presentations, shiftwork information, fitness and lifestyle presentations, and a back care program.
- ☐ Visit detachments, determine their fitness equipment needs, advise on type of equipment purchases and contacts for these purchases.
- ☐ Administer the Canadian Physical Activity Fitness and Lifestyle Assessment to members in the field.
- ☐ Develop and deliver various special activities that promote healthy lifestyle practices.

PROCESS

The process and action plan for this particular program and its goals has varied due to the nature of the RCMP organization. For the Detachment Fitness Coordinator program, information was submitted to the various subdivisions in order to get approval to release members for the project. Once this was completed, names and qualifications were submitted to the office in order to select the most qualified individuals. Then the training courses were organized and the individuals trained. There is ongoing communication and training.

Information sessions and training talks have been developed through utilizing various information and programs from a number of organizations. With respect to shiftwork information, the "Shifting to Wellness" program (developed through Keyano College in Fort McMurray) has been adopted. In addition, various nutrition resources through other organizations (Dairy Council, Alberta Registered Dieticians, Becel, etc.) have been acquired. Other sources include Alberta Centre for Wellbeing, Alberta Fitness Leadership Certification Association, Alberta Heart and Stroke Foundation, Alberta Lung Association, Vitality, and others.

ONGOING COMMITMENT AND LEADERSHIP

Financial backing and management support is 100 percent for a three-year commitment from the RCMP. All of the DFLAs were hired on a three-year contract as advisors to initiate the program in each Division. This has been incorporated into the Health Services Team and it is anticipated that the program will continue after the contract is complete.

All of the DFLAs work closely together in formulating and supporting projects nationally, in addition to sharing resources and ideas.

MODEL/FRAMEWORK

There is no one model that has been adopted for this particular program. The focus is more of an awareness campaign for the first three years. A program is being developed as the process continues. By the end of the three-year term, programs will be put in place that will be self-monitoring and operational.

EVALUATION

A formal evaluation is in progress. Some of the information from the Health Promotion Survey will be used as baseline data and, in addition, other information collected over the past 1.5 years for measuring will also be used.

IN YOUR OPINION

Based on my perceptions of the process, the idea of this program is a very important benefit for members of the RCMP. The advisors are working with the other Divisions to ensure program consistency across Canada. All of the Division Fitness & Lifestyle Advisors were hired to initiate a program. They are still in the beginning stages of an Employee Wellness Program. Due to the nature of this organization, the nature of police work and the fact that this is a national organization that is decentralized throughout the country, it is impossible to incorporate one model that will work for the entire employee population.

The primary challenge faced is distance between the plan and the members. Geographically there are a variety of circumstances that challenge the program. There are unequal resources (fitness equipment, human resources such as registered dieticians, physiotherapists, etc.) in each of the detachments across Canada. Some members live in isolated areas where the only access to their locations is via aircraft.

Another challenge is working within a large organization which is undergoing a lot of change. Like most organizations the program fits into a complex matrix of organizational stresses such as organizational restructuring, financial concerns and less human resources to do the same work. The task of Fitness & Lifestyle Advisors is not just to get members healthy with respect to their fitness. Rather, it involves all aspects of the Wellness model. This in itself is the challenge. It is anticipated that, not unlike most Wellness programs, our impact will take up to 10 years for the organization to actually see some objective results. Most wellness programs take time to implement, to be accepted by the masses and to visibly impact the organization.

The DFLAs are in the forefront of developing and implementing this Wellness program. They are not only developing but are actually running the program. They have been hired as professionals to initiate this project. Therefore, it is their responsibility to make it work.

A process that should have been initiated from the first day was to do more planning with all of the other DFLAs in conjunction with Ottawa. As a group we are now setting goals, evaluating procedures and programming on a national level. This process in itself has taken us 1.5 years to start. However, as we are progressing, the program is having more impact on the members and the RCMP as a whole.

Continued....

In conclusion, I would like to reiterate that this program is still in the beginning stages. We are developing and implementing as we go along. The challenge of learning how an organization works has been the biggest learning process over the past year. The information provided to you for your survey may not be all inclusive, as we are still somewhat in the planning phases. With the initiation of this program, the RCMP is taking the right steps toward providing a holistic approach to their Health Services.

COMMUNITY HEALTH

CHAPTER TWO

Communities that have implemented various strategies have healthier populations than communities that have remained inactive. Despite the globalization of our economy and major transformations in the labour force, certain communities, regions and industries have found ways to maintain the dignity of employment for most of their citizens. We have seen that with a little bit of imagination, some financial support and a lot of enthusiasm, communities can act to reduce substance abuse, delinquency, suicide, school drop-out rates, neglect, abuse and violence. They can also support positive health practices such as healthy eating and physical activity. For example, we have learned about many ways that communities promote healthy aging and enable seniors to play a more significant role in society.

—National Forum on Health, 1997

OVERVIEW

Chapter Two first highlights current themes prevalent in the community health setting.

Case studies are then presented under the following three categories:

COMMUNITY PARTNERSHIPS

- *Dalhousie University, Nova Scotia*
- *Challenge, Yukon*
- *University of Regina, Saskatchewan*
- *Clinidata, Quebec*

COMMUNITY HEALTH INITIATIVES

- *Health and Community Services Agency, Prince Edward Island*
- *PEI Heart Health Initiative, Prince Edward Island*
- *Community Health, St. John's Region, Newfoundland*
- *Lutsel K'e First Nations, Northwest Territories*
- *Indian Health Services Region, Northwest Territories*

EDUCATIONAL INSTITUTIONS

- *Red River College Wellness Committee, Manitoba*
- *Eastern School District, Prince Edward Island*

The case studies are considered as follows:

- *Initiative*
- *Leadership*
- *Needs Assessment*
- *Goals*
- *Process*
- *Ongoing Commitment and Leadership*
- *Model/ Framework*
- *Evaluation*
- *In Your Opinion*

CURRENT THEMES

> *Under prevention and promotion rubrics, we hear of community education, community programs, community participation, etc. However, the meaning of a community focus is less clear. At the very least, community usually means 'not in a hospital, clinic or doctor's office.' Community is the great 'out-thereness' beyond the doors of professional offices and facilities—the social space beyond the edges of our professional systems.*
>
> —McKnight 1994

THE COMMUNITY SETTING

"Community" encompasses a neighbourhood or village and various places conducive to interpersonal relationships and solidarity, such as schools, workplaces and one's social environment (National Forum 1997).

The Determinants of Health Working Group Report delivers a clear central message:

> *Non-medical interventions can significantly enhance people's health, and medical care is only one way, and not necessarily the most significant one, to regain, maintain and improve health.*

To support their findings, the Working Group provides several key examples of success stories from across Canada and other parts of the world. These success stories focus on the non-medical determinants of health, and are promoted at the level of the community. (The lessons learned from reviewing these success stories are crucial to the development of the present study.) The report states that "just as there is no pill for preventing or curing cancer, there is no single solution or magic bullet that will solve social and economic problems."

They argue that much can be done to prevent massive social change from damaging health, and that a new philosophy is required wherein population health is a societal goal as important as economic development. The community can be seen as encompassing settings, "while also having many unique features of its own as a setting for health promotion."

SUPPORTING THE FAMILY

> *Families who are supported in their communities and receive the help they need with parenting will be more likely to raise healthy children.*
>
> —Health Canada 1995

National goals that "focus on healthy development and its many biological, emotional, social and economic determinants" are the first step in a continuous participatory process for improving the health and well-being of Canada's young people (Health Canada 1995):

- ☐ Value all children and youth in Canada, and share responsibility for their healthy development.
- ☐ Support families in their role as the primary caregivers of children.
- ☐ Make health promotion and prevention of disease, disability and injury among children and youth a priority of healthy public policies.
- ☐ Reduce child and youth poverty.
- ☐ Protect children and youth from abuse, violence, inequity and discrimination.
- ☐ Ensure that young people have opportunities to participate in decisions about their healthy development and encourage them to make healthy life choices.
- ☐ Strengthen the capacity of communities to promote and improve healthy child and youth development.
- ☐ Develop collaborative, cost-effective strategies to achieve measurable improvements in health outcomes for children and youth.

> *The central role of the family as a potential refuge and place of social, emotional, and moral development is undisputed. While family types and structures may vary, the role of family as a nurturing and cohesive force extends across time and throughout cultures.*
>
> —Mangham et al. 1996

Mangham and others (1996) are interested in exploring what makes some families resilient and in what ways this concept might be used in policies or programs. They define resilience as:

> *... the capacity of individuals and systems (families, groups, and communities) to cope successfully in the face of significant adversity or risk. This capability changes over time, is enhanced by protective factors in the individual/ system and the environment, and contributes to the maintenance of health.*

At least five key factors appear consistently within resilient families: family stability, family cohesiveness, adaptability, collective stress coping skills, and strong internal and external support networks.

> *Today, we are working with a concept that portrays health as a part of everyday living, an essential dimension of the quality of our lives....Health is thus envisaged as a resource which gives people the ability to manage and even to change their surroundings....Viewed from this perspective, health ceases to be measurable strictly in terms of illness and death. It becomes a state which individuals and communities alike strive to achieve, maintain or regain, and not something that comes about merely as a result of treating and curing illnesses and injuries. It is a basic and dynamic force in our daily lives, influenced by our circumstances, our beliefs, our culture and our social, economic and physical environments.*
>
> —Epp 1986

COMMUNITY PARTNERSHIPS

CASE STUDIES

CENTRE FOR WORK AND HEALTH
Dalhousie University, Nova Scotia

COMMUNITY VOCATIONAL ALTERNATIVES
Challenge, Yukon

WELLNESS MOBILE
University of Regina, Saskatchewan

TELE-CARE PILOT TRIAGE PROGRAM
Clinidata, Quebec

Health is not an input. Health is not a commodity. Health cannot be consumed. Health is a condition. Health is the by-product of strong associative communities. Health is the unintended side effect of citizens acting powerfully in association.

—McKnight 1994

CENTRE FOR WORK AND HEALTH

Dalhousie University, Nova Scotia

INITIATIVE

The Centre for Work and Health was established as a partnership with the ultimate goal of providing expertise to Nova Scotian industries in the development of health and productive workplaces. The Centre provides a wide range of professional services ranging from proactive ergonomics assessments, education and recommendations, to immediate post-injury care, and when necessary, rehabilitative care, and work re-entry. The services offered include both on-site and in-clinic educational programs focusing on safety, human capabilities and capacities, and workplace analysis and design.

The idea for the Centre for Work and Health at Dalhousie was generated by two faculty members who had an interest in workplace health by way of an initial interest in ergonomics. Through discussion with others (a private physiotherapy clinic owner located at Dalhousie), it was felt that a comprehensive program of services could be provided by developing a partnership.

After considerable planning, the initiative was started in the fall of 1995. In two years it has emerged as a self-financing service to the Dalhousie University community and the larger external community.

LEADERSHIP

The original coordinating leadership was with the Director of the School of Health and Human Performance. A Board of Directors was created, but the day-to-day management of the Centre's business was by a Management Committee comprised of a representative of the three major partners: the School of Health and Human Performance, Athletics and Ancillary Services (Dalhousie University) and the Physioclinic (the private firm).

From the outset, the three partners saw their contributions as equal. Each partner supported the venture with seed money in order to contract an individual to coordinate and manage the Centre in its early stages.

NEEDS ASSESSMENT

No formal needs assessment was conducted. The combined experience of the three partners led to the conclusion that there was a market for the variety of services offered.

GOALS

The goal of the Centre was to provide a comprehensive set of services from initial physiotherapy treatment of the injury, to work rehabilitation, to work place assessment, to educational programming, all designed to improve workplace health and safety. Through the provision of this range of services, other goals were seen as achievable: the generation of research projects, the generation of education opportunities for senior undergraduate and graduate kinesiology students, and the provision of work opportunities for graduates of the Kinesiology and Health Education programs.

The major goal of improving workplace health and productivity is served by the application of ergonomic principles and concepts dedicated to the understanding and improvement of human performance.

In pursuit of its overriding objective, the Centre for Work and Health plays three major roles:

- ☐ education of undergraduate and graduate students focusing on applied problems related to health and safety in the workplace
- ☐ education of the members of workplace communities about the application of ergonomics for a safer and healthier environment
- ☐ application of a research capacity through applied and basic research in human motion analysis specifically related to the workplace and the efficacy of therapeutic interventions

The approach to research in the Centre for Work and Health may be multiprofessional and/or multidisciplinary, depending on the research problem.

PROCESS

This question is not easily answered in view of the nature of the Center's work and goals. Much of the 'action' to this point has been awareness development in relevant communities. The major goal at the time of writing is to make sure potential users of the Centre are aware of its existence and services.

ONGOING COMMITMENT AND LEADERSHIP

The commitment is high and ongoing. The Centre has proven itself to be financially feasible which has allowed it to extend the contract of the manager responsible for expanding the "business". Support from the three partners remains strong.

MODEL/FRAMEWORK

This model is essentially one of partnership for comprehensive service. The Centre is convinced that the partnership expands the comprehensive nature of the offerings and develops a setting in which service is one of many outcomes. The capability of research by way of connection with an academic unit improves the possibility of development over time. The involvement of students heightens awareness about the usefulness of this work. Again, this awareness produces a long-term benefit for the community at large, as educated individuals participate in their varied roles in society with a much richer knowledge of the needs and possibilities related to workplace health.

The Centre for Work and Health values partnerships with community agencies and believes it is important to be working cooperatively with a broad base of individuals in seeking solutions to very complex problems. For example, the Centre is currently working with the Technology Assessment Development Centre (TADC), an agency sponsored jointly by the Nova Scotia Department of Education and Culture, the Nova Scotia Workers' Compensation Board and IBM Canada. TADC provides computer software training to disabled individuals who require vocational rehabilitation training or job retraining.

In this partnership, the Centre for Work and Health at Dalhousie provides workplace ergonomic assessment for the purpose of defining "what is needed"—that is, evidence for decision making. The Centre also provides TADC with research expertise in program and product (assistive devices) evaluation. In this respect, the model upon which their work is based is very compatible with the principle espoused by the Health Services Research Foundation: "...decisions...should be based on real evidence about what works and what does not...". It is in this sense that the Centre can play a valuable role in developing healthy workplace environments. It is a general model adaptable to a multitude of work environments such as hospitals, fish plants, forestry locations and construction sites.

Another current project being piloted by the Centre for Work and Health will result in a model that ultimately reduces the cost of workplace injury and illness. The Centre is working with Pratt and Whitney to establish an in-plant Ergonomics Committee. This will result in local staff being able to conduct preliminary workplace assessments and interventions. Such a committee would do the ground work prior to hiring consultants. It has been shown in the past that employee compliance and acceptance of change in the workplace is most effective when they are involved in the decision making process. It is also fully recognized that when it comes to identifying workplace problems, whether they be quality or health and safety in nature, employees make valuable contributions to the process because they understand the work and its inherent problems.

Finally, the Centre recognizes that solutions to workplace health and injury reductions are a very complicated matter that should not focus solely on a reduction in the incidence of illness/injury (e.g. back pain). It has been demonstrated that, even though the incidence of back pain may not be lowered, proper training related to dealing with the injury can reduce the rate of absenteeism and reduce the cost of each claim. Research, therefore, must focus on the development of models for "outcome research."

EVALUATION

The single most important point of evaluation will be an assessment of whether or not the demand for the Centre grows. Growth will reside in the quality of service it provides, and the success achieved in improving the quality of health in the workplace.

IN YOUR OPINION

The Centre appears to be a success at this time as it has progressed from a subsidized operation to a self-financing operation.

A variety of businesses have accessed the Centre as well as two cooperative projects with the Workers' Compensation Board. There is an expanded role without the university.

If it were to be done differently, I suspect we would have sought external funding as seed money and done more preliminary needs assessment work to better pinpoint potential markets and clients.

COMMUNITY VOCATIONAL ALTERNATIVES

Challenge, Yukon

INITIATIVE

Challenge is a registered society and its overall mission is "to assist people with disabilities in achieving their employment goals in the Yukon."

Originally (over 21 years ago) it was a training facility/sheltered workshop for adults with mental disabilities. Since 1988 it has redefined the role and begun to provide community-based supported employment opportunities for consumers. In addition, it has created an affirmative industry called Career Industries Ltd. Though Challenge provides an invaluable service, it was felt that consumers would have a greater chance at employment if they received formal training in a college environment and supported on-the-job experience.

Challenge partnered with Yukon College to develop and deliver several training courses designed specifically for adults with disabilities. These courses include: Construction Site Helpers, Janitorial Helpers, Office Helpers, Service Station Helpers and Kitchen Helpers.

These programs were initiated in February 1995.

LEADERSHIP

Challenge assumed the leadership role of developing the programs in partnership with Yukon College. Challenge became responsible for the coordination and delivery of the programs. The College was responsible for program development and delivery of the classroom portion.

NEEDS ASSESSMENT

Based on placement numbers in the local job market, it became apparent that there was a high level of need in the food preparation industry. Therefore, our first project was to provide a kitchen helper.

GOALS

The overall goal was to provide a job preparation program to individuals with disabilities in order to reduce their dependency on social programs and enhance their self-esteem and self-sufficiency.

The specific objectives were to:

- ☐ Assist individuals with disabilities to acquire task-oriented skills that will lead to employment.
- ☐ Provide opportunities for individuals with disabilities to increase generic interpersonal and social skills that are required when seeking a job and for maintaining competitive or supported employment.
- ☐ Increase the self-concept and attitude of individuals with disabilities by ensuring success in interpersonal and task related skills.
- ☐ Determine the impact of remuneration on the level of participation in and completion of training programs for individuals with disabilities.

PROCESS

Fifteen-week programs were organized. The first seven weeks are classroom-based training through the Yukon College. The following eight weeks are on-the-job work experiences in a community-based worksite. Participants are paid a wage of $7.50 per hour for 7.5 hours per day for 37.5 hours per week. Both the classroom component and the work experience component are treated as an actual job. Therefore, participants are expected to perform to employers' expectations at all times. This is especially important with attendance and punctuality. Any lates or absences without valid reason are not paid. Participants quickly learn how important it is to arrive on time and to be prepared for work.

ONGOING COMMITMENT AND LEADERSHIP

There is a high level of commitment from all involved groups, including the funding agency.

MODEL/FRAMEWORK

For most people, obtaining a job is an important aspect of self-sufficiency. Employment provides a source of income, a sense of self-fulfillment and an opportunity for social interactions and relationships. While a majority of society is able to obtain employment independently, many individuals with disabilities require extra assistance, training and support. Over the years there have been many training programs; however, it has been noted that the majority of jobs were lost due to social behaviours, rather than an inability to perform the tasks. Some of the specific areas that led to the termination of employment are lack of social skills and life skills. These include work-related adjustment problems, such as attendance and punctuality; personal adjustment problems (e.g. hygiene and grooming); and social and interpersonal problems.

Through experience, vocational lifeskills were identified as an essential training area.

EVALUATION

The whole project, consisting of several training courses, is currently being reviewed by an independent consulting company.

IN YOUR OPINION

Based on our perceptions of the project, we definitely consider this model to be a success. This success is indicated by the course completion rates of the participants and the numbers of jobs obtained following graduation. Our total completion rate averages 75% from all projects to date. The average number of jobs obtained by graduates is approximately 65%.

The staff at Challenge jointly developed this model of program delivery. It has been dubbed the M.A.S.T. model of training (Motivation, Assistance, Skills Training).

This model has been used for several skills based programs described herein.

If we were to do this again, we would try and secure funding for several projects at once so that we could plan more coherently and recruit students.

WELLNESS MOBILE

University of Regina, Saskatchewan

INITIATIVE

In the early 1990s Saskatchewan went through a process of health reform which included the development of provincial health districts which regionalized much of the delivery of health services. This process created a need within the province for resources to be available to these districts, especially in the development and implementation phase of district services. Saskatchewan is a geographically vast province, with the population spread over a large area. The resources for these districts, therefore, had to be mobile.

The Dr. Paul Schwann Applied Health and Research Centre of the Faculty of Physical Activities Studies at the University of Regina has been an integral part of the University and the Regina health community for over 25 years. Established in the early 1970s, the Centre is best known for the provision of cardiac rehabilitation and risk reduction programming. The Centre also provides musculoskeletal rehabilitation, corporate wellness services, health promotion and education services, and health, fitness and lifestyle research. In 1994 the Dr. Paul Schwann Applied Health and Research Centre submitted a proposal to Saskatchewan Health for the development of a "Wellness Mobile."

The premise of the Wellness Mobile program was to provide services not available to health districts and rural communities. These services were available through a mobile unit which provided programming in consultation and with cooperation of health districts. In addition, the program established a provincial network of partnerships consisting of organizations working toward common goals. The Wellness Mobile proposed to do this while making use of existing local and provincial infrastructure and programming.

The proposal submitted to Saskatchewan Health was accepted. Funding, in addition to an agreement of support, was provided in the summer of 1994 to begin the Wellness Mobile program. In September of 1994 the Wellness Mobile program officially began.

LEADERSHIP

The Dr. Paul Schwann Applied Health and Research Centre housed and operated the Wellness Mobile program. The support from Saskatchewan Health was vital in establishing the program. In addition, the health districts in which work was completed were driving forces behind their respective projects. The cooperation and support of the partner organizations was also vital in establishing programs across the province.

NEEDS ASSESSMENT

As outlined above, there was a need to have mobile services available to the newly established health districts. In addition, each health district completed its own needs assessment. Each individual program offered by the Dr. Paul Schwann Applied Health and Research Centre Wellness Mobile was initiated as a result of an established need existing within that district, as determined by the district's needs assessments.

GOALS

The goals of the Wellness Mobile program were to:

☐ Promote healthy lifestyle choices to rural residents and to identify the needs of individuals in rural communities through various health assessments.

☐ Provide resources on current health-related concerns and issues.

☐ Establish community partners for the promotion of health and well-being and to increase continuing local programs and services.

These goals provide the foundation on which any project is built. Each individual program that the Wellness Mobile initiates with a health district attempts to meet these goals by operating on a seven-stage process.

PROCESS

The Seven-Stage Process

The seven-stage process was designed to make the operation of the Wellness Mobile program the most effective and efficient possible. Working in conjunction with many organizations and individuals can become very difficult unless a protocol for the process is established.

☐ Stage One: The Wellness Mobile office contacted by a health district to inquire about program possibilities

☐ Stage Two: A meeting of the health district and the Wellness Mobile during which the Wellness Mobile program was outlined and possibilities were discussed, based on the needs of the health district. As part of this stage the health district and the Wellness Mobile established an overall action plan and one or more contacts within the district were identified to work with the Wellness Mobile program.

☐ Stage Three: The consultation and collaboration with each contact and the development of detailed action plans. In this stage long-term programming options were discussed and detailed evaluation plans were established.

☐ Stage Four: The development of the program itself and the promotion of the program at a community level. Appropriate tools were developed and tailored for each target group and community. It is during this stage that a provincial or local partner organization may be brought on board to help fit the program to the needs of the target group or to establish long term programming options.

☐ Stage Five: The implementation of the program in the community. Initial evaluations were completed and links were made for ongoing program possibility.

☐ Stage Six: The follow-up and outcome evaluation of the program with the results being reported to all involved in the process.

☐ Stage Seven: A maintenance level, which is often ongoing. This stage may involve further programming by the Wellness Mobile, program support, or resource sharing/gathering.

ONGOING COMMITMENT AND LEADERSHIP

The Wellness Mobile programs are unique and diverse. Each program developed and delivered had, and continues to have, its own challenges and strengths. Overall, the programs in all areas of Saskatchewan had outstanding support and commitment from the health district staff with whom we worked. Great support was received from the communities in which these programs were implemented. In addition, the support of the provincial partners of the Wellness Mobile was, and continues to be, outstanding.

Financial backing of the program is an ongoing concern. Saskatchewan Health funded 80 percent of the program costs through the first two years of operation. Bi-Rite Drugs, a provincial drug store chain, came on board with a contribution in 1994, assisting through the first year. In 1995, the Canadian Pacific Charitable Foundation established a five-year plan for financial contributions to the program. The program lost 80 percent of its funding in 1997, raising some interesting challenges which they are working to overcome.

MODEL/FRAMEWORK

The Wellness Mobile program has operated throughout its existence based on the goals outlined above. All programs implemented by the Wellness Mobile were developed and delivered based on meeting these goals. Each program implemented was designed to meet the needs which existed in a particular community or health district. Therefore each project "model" was unique, and designed to meet the needs which existed within that specific population. All projects were implemented following the seven- stage process outlined above.

Three key factors came into the functioning of the Wellness Mobile program:

- ☐ The first key was the link established between the rural health districts and communities in providing health and wellness programming to rural residents. This type of programming cannot succeed without the support and work of local people.
- ☐ The second key was the flexibility of the programs the Wellness Mobile offered. This flexibility allowed the program to meet the needs of the district and community in which work was being completed.

☐ The third key was the valuable partnerships which have been formed with other provincial organizations. This aspect allowed it to provide as many programming options to districts as possible. It also allowed the elimination of duplicate programs and offered the best possible programming to rural residents.

EVALUATION

Evaluation was completed for each project the Wellness Mobile undertook. The process of evaluation varied depending on the project structure and function. Surveys, questionnaires, quality of health self-assessments, and physical health assessments were used as quantifiable measures, both initial and follow-up. Evaluation results from these measures have shown improvement in flexibility, cardiovascular function and body composition results. In addition, questionnaire data has seen improvement in reported physical activity levels and quality of life.

The most obvious measurable evaluation of our programs has occurred in observing the sustainable community-based programs generated in rural Saskatchewan. These programs included the establishment of community walking programs, older adult exercise programs, workplace exercise facilities and youth sports injury prevention programs. In addition, formal and informal feedback has been received from the Health Districts and individuals involved in the programming. The results of these evaluations were very positive and also provided some feedback which helped to improve the programming and the process of providing programs.

IN YOUR OPINION

I consider the Wellness Mobile program to be successful on many levels. First, evaluation results show that it aided many people in improving lifestyle choices. Second, many community programs were generated which foster an environment of support for healthy lifestyles in the community, increasing opportunities to make healthy choices. Third, it created a network of provincial organizations which worked together to reach a common goal, decreasing duplication and fostering relationships which will lead to future cooperation and support. Fourth, it provided another resource for Health Districts to access in their time of development.

The Wellness Mobile program is very unique and thus was a challenge in that no "blueprint" existed. The program has improved throughout the three years of operation, as evaluation results and outcomes were measured and program adjustments were made.

I don't feel that we created a model and then handed it over for others to use. The Wellness Mobile program developed each project in conjunction with Health District and community members. The program was never handed over in effect because no group ever really "owned" it. The Wellness Mobile program remains in contact with all of the Health Districts in which it has completed work. The process continues and we provide support in any way we are able. I believe this community or district ownership is vital in establishing any type of program like this. The chances of success are much greater if the individuals who will benefit from it have a hand in developing it.

When the program was established in 1994 it was open to any Health District that wished to access it. Since the recent loss of a majority of our funding, the program has had to restructure and now operates on a cost recovery basis. This has obviously limited the number of Health Districts which can access our services, although we continue to travel across the province providing health and wellness programming.

Individual Wellness Perspective

One of many participants in the Wellness Mobile was the Bethany Pioneer Village.

The Wellness Program had such a strong impact on our facility and our enthusiasm for fitness.

We are very fortunate to have staff members who have taken charge and developed what is called our Fitness Centre. There was available space in the lower level of our Assisted Housing Facility and, because we are a small community, it was one place that was not locked up, nor did someone have to be specifically responsible for it. This facility is attached to the Special Care Home. Therefore, there are staff on duty 24 hours a day at both facilities.

We are located about one-half mile outside our small town of Middle Lake. The setting makes it feel like a bit of a resort. The walk down to the facility is, in itself, exercise. We are located right beside a provincial park, which encourages outdoor sports such as swimming, skiing and ball.

When the Wellness Program was introduced to the Bethany Pioneer Village Home, our Fitness Centre had just opened and we all needed a pep talk on the importance of individual areas of improvement. That is exactly what we received. The week that David Lee was here, staff were on the highest level of energy we ever had experienced. Staff were ecstatic about their own strengths and were enthusiastically looking forward to improving their weaknesses.

We had allowed and encouraged all staff members to participate, and did so on working time. That left an impression with the staff that management supported and encouraged physical well-being and could recognize the overall benefits to the care of our residents.

Some of our staff who exercise, stay in shape, belong to weight loss groups, etc., rated very well. Therefore, we had those peers to look up to and see the difference that it has made to their health versus some less active individuals.

Continued......

It has been nearly a year since we had our assessments, and we were looking forward to our annual update with the Wellness Program just to get us going again. Unfortunately, the funding for this program has been cut, and it is no longer available free of charge. The cost for an assessment is about $40.00. When compared with other things, that is not a lot of money but, for some reason, when we feel relatively healthy, we hesitate to pay.

I definitely have seen the importance in our children's lives and we have encouraged them to be involved in many extracurricular activities such as dancing, skating, skiing, and hockey. We all work together on the farm and promote doing chores together with the children. We promote a positive outlook, feel good about physical work or exercise and talk about its importance.

The Wellness Program is a must to the well-being and improvement of our overall health. Management is in the process of addressing this issue, and possibly some funding will be approved for the Wellness Program to return.

I cannot say enough about this experience, for which I am grateful. Our fitness centre remains active.

Staff Member
Bethany Pioneer Village
Middle Lake, Saskatchewan

TELE-CARE TRIAGE PROGRAM

Clinidata, Quebec

INITIATIVE

In a study to fulfil the requirements for her Master's Degree in Nursing, Lois Scott of Moncton, New Brunswick, evaluated the role of anxiety and its precursor, uncertainty, in the information seeking and coping strategies of New Brunswickers who visited Moncton area emergency departments.

Through her review of the literature and active review of Emergency Room (ER) records, she determined that up to 70 percent of visits to the ER in New Brunswick were for non-urgent reasons. Furthermore, she found that the visit to the ER reduced anxiety through the delivery of symptom-related health information and advice. She postulated that a telephone service, much like that used in poison control, could effectively improve patient coping and reduce unnecessary visits to hospital ERs. This was confirmed by U.S. literature which showed that patient access, hospital costs and physician satisfaction could be optimized through the use of telephone access to "just-in-time" health information and advice.

The original two-year Tele-Care pilot triage project began in Moncton, New Brunswick in January 1995.

LEADERSHIP

The original concept was created through a partnership between the New Brunswick Department of Health and Community Services and the Region One Hospital Corporation in Moncton, New Brunswick. A 16-member steering committee was formed and two local emergentologists acted as medical directors for the pilot.

The Department of Health and Community Services, the hospital corporations, and a nurse manager with a team of nurses worked closely with the steering committee to increase public awareness and optimize the quality of the program.

The team of nurses and the hospitals had support from the community at large, and from key internal resources such as the Hospital Information Systems Department.

NEEDS ASSESSMENT

The needs assessment was completed based on the findings of L. Scott's thesis. Her thesis assessed the needs of patients seeking aid in the region's ERs, the community at large, and the hospital corporation.

GOALS

The goals of the Tele-Care Pilot Triage Program were to reduce utilization of the province's Emergency Departments for non-urgent conditions, increase the public's awareness of the service, measure utilization of the service, demonstrate patient satisfaction, demonstrate cost effectiveness, and monitor visits to the ER.

PROCESS

A call centre has been set up in Moncton, New Brunswick, after the completion of the two-year pilot project. In January 1997 Clinidata Inc. opened a Health Management Call Centre employing approximately 30 full- and part-time nurses. Using a set of computer-generated algorithms, the nurses take calls 24 hours a day in French and English regarding the symptoms of callers or their loved ones. They then ask the callers questions based on a set of medically approved triage guidelines. They follow these guidelines to a disposition which allows the callers to decide between seeking immediate care, seeking care from their primary care physician within 24 hours, seeking help from other community resources, or doing self care. No diagnosis is made. The advice regarding disposition is based solely on the patient's symptoms and the ability to give an adequate history. The nurses will choose to refer in order to prevent adverse outcomes.

The nurses have a database of health and drug information which can be shared with the caller via fax, letter, or through the use of an automated voice response system.

Clinidata Inc. is responsible for the overall operation of the call centre and therefore the Tele-Care program. The Director of Clinical Services and head of operations for the call centre is a Clinidata associate who has designed a workflow management process and training program for telephone triage in New Brunswick. A model of care, which is very successful in the United States, has been adapted to the New Brunswick environment. The plan is to enhance the concept of population health management through the use of the call centre concept. By doing so, access to nurse advice and other enhanced tele-health services can be provided to the general public and private sector organizations. The benefits of this accrue to both the population served and in the form of direct employment benefits for highly skilled nurse providers.

ONGOING COMMITMENT AND LEADERSHIP

Management support has been outstanding, from both the management of Clinidata and the Government of New Brunswick. The staff and financial backing of the program are also excellent.

MODEL/FRAMEWORK

The theory and practice of telephone advice/triage is based on the role of information-seeking as a coping strategy. Also, adult learning theory dictates that one learns best at the point of performance: when faced with a condition, one is ready to learn about it.

EVALUATION

The government is preparing an outcomes study of this program. The evaluation procedure involves collecting data from the community, from the government claims database, from local hospitals and via surveys. The software used to provide the services also produces extensive formal and informal reports.

There is a continuous quality improvement (CQI) process which is driven by the results from the qualitative consumer surveys and the quantitative data from the software. Every month appropriate changes are implemented based upon the results of the CQI process.

There is direct evidence from the project which indicates that:

- ☐ Consumers are influenced in their decision making by health information and advice.
- ☐ Consumers are very satisfied with the concept of telephone advice and counseling.

IN YOUR OPINION

If we were planning the project over again, we would have placed more emphasis on information systems early on in the project. In addition, more time needs to be spent educating patients and providers on the benefits of prevention and health information. By involving all stakeholders you have a better chance of integrating the various models of care, thereby optimizing both health and economic outcomes.

COMMUNITY HEALTH INITIATIVES

CASE STUDIES

HEALTH INFORMATION RESOURCE CENTRE
Health and Community Services Agency, Prince Edward Island

EASTERN KINGS HEART HEALTH PROJECT
PEI Heart Health Initiative, Prince Edward Island

HIV AND SUBSTANCE USE
Community Health, St. John's Region, Newfoundland

BABY'S COMING, BABY'S HOME
Community Health, St. John's Region, Newfoundland

MENOPAUSE/ OSTEOPOROSIS FORUM
Community Health, St. John's Region, Newfoundland

YOUR HEALTH, COMMUNITY HEALTH
Community Health, St. John's Region, Newfoundland

HEART SMART RESTAURANT PROGRAM
Community Health, St. John's Region, Newfoundland

MENTAL HEALTH CRISIS CENTRE
Community Health, St. John's Region, Newfoundland

LUTSELK'E FAMILY LEARNING CENTRE
Lutsel K'e First Nations, Northwest Territories

BRIGHTER FUTURES: BUILDING HEALTHY COMMUNITIES
Indian Health Services Region, Northwest Territories

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies.

—Ottawa Charter, WHO 1987

HEALTH INFORMATION RESOURCE CENTRE

Health and Community Services Agency, Prince Edward Island

INITIATIVE

In 1994, in response to recommendations made in the "Health Promotion Working Group Report" (May 1993), the Community Development Division of the Health and Community Services Agency (now the Health Promotion and Protection Division of the PEI Department of Health and Social Services) established a planning committee. Its mission was to develop the vision and structure of a Health Promotion Resource Centre (later called the Health Information Resource Centre). Membership in the committee included representatives of the health system and community organizations.

In the fall of 1995 the Agency endorsed the development of the Health Information Resource Centre as a three-year pilot project pending ongoing community commitment. Since that time, a Coordinating Committee for the Centre has been established.

The Health Information Resource Centre opened its doors in June 1996.

LEADERSHIP

Although the then Community Development Division of the Health and Community Services Agency led the process, the initiative moved forward through community and health systems partnership.

The level of commitment and participation was high in both the health system and in the community. Funding was dependent on evaluation and ongoing community support, both of which have been very positive. The Centre's volunteer coordinating committee is very dedicated and has contributed many services in kind.

NEEDS ASSESSMENT

During the planning phase of the Centre, the need for health information was identified by those inside (health care service providers) and outside the health system.

A number of studies identified the need for accessible, user-friendly health information. These studies included:

- ☐ Assessment of the Needs of First Generation Ethnic Seniors, PEI Multicultural Council, 1995
- ☐ Sandwich Generation Assessment
- ☐ Advisory Council on the Status of Women, 1994
- ☐ Community Needs Assessments
- ☐ PEI Health and Community Services System, 1994/1995
- ☐ Environmental Contact Scan, Community Health Promotion Network - Atlantic, 1994
- ☐ Review of Nutrition and Dietetic Services
- ☐ Health and Community Services Agency, 1995
- ☐ Survey of the Health and Community Services System Regarding Library and Information Services, Health and Community Services Agency, 1995
- ☐ Health Information Project for Financial Assistance Clients: Evaluation Report, Health and Community Services Agency, 1994
- ☐ Public consultation through a community meeting

Results of these needs assessments indicated that public access to information was limited and fragmented, and that an accessible provincial resource centre for health information was desired. It was also evident through the consultation process that community organizations did not want the Centre to duplicate or replace existing services, but rather to complement and support existing programs.

GOALS

The Health Information Resource Centre (HIRC) is a provincial health promotion initiative designed to improve access to information for all residents of PEI, thereby providing them with the opportunity to increase control over and improve their health.

The objectives are:

- ☐ Enable access to information.
- ☐ Gain a greater understanding of the impact of information on the health of individuals and communities.
- ☐ Gain a greater understanding of health information needs.
- ☐ Make the Health Information Resource Centre and its functions visible and inviting.
- ☐ Ensure future sustainability in accessing information.
- ☐ Respond to the recommendations of ongoing evaluations.

PROCESS

As a result of the needs assessment, communities were heavily involved in planning and implementing the project. Access to information not available elsewhere was provided. Islanders were directed to other sources of information and support services, and community organizations were worked with to develop new health education material and to assist in its dissemination.

ONGOING COMMITMENT AND LEADERSHIP

An evaluation was recently completed. Commitment, ownership and involvement by staff, the coordinating committee, community organizations, and health professionals are extremely high. Management also supports the work of the Centre. The pilot phase of the project ends in March 1998, and negotiations with the Department of Health and Social Services for ongoing core funding are in progress; however, outside funding for project work already carried out has been received. There are a number of placements for community and academic institutions, which helps move the agenda forward.

MODEL/FRAMEWORK

The process is one of community involvement, system and community partnership. Although not explicitly stated, the principles followed include mutual respect, cooperation, collaboration, openness and honesty.

EVALUATION

A formal evaluation was completed in the summer of 1997. The effects of the project on clients, staff and the community focused more on satisfaction than outcome.

A review of the results of this evaluation indicated that HIRC has been largely successful in achieving objectives. Much has been learned about the health needs of Islanders, the impact of this information, and how this information should be delivered. In its first full year of operation, HIRC has witnessed a demand for the service from health professionals, students and the general public.

HIRC has been managed efficiently, and the management structure is an example of a successful working partnership between the government and the community. Client satisfaction is high, largely due to skilled staff who provide relevant and appropriate information to clients.

Further study is warranted in terms of the impact on health; however, the findings suggest that HIRC does provide a mechanism whereby individuals can make more informed decisions about their health, and the information is assisting Islanders in caring for themselves and others. Increased knowledge and self-care have the potential to reduce the demand on already overburdened health care services. Furthermore, access to health information is also consistent with current health policy which promotes more responsibility for one's own health.

The service has had a positive impact on individuals and health professionals, and promotes partnerships with other community resources. On an individual level, Islanders are using the information to increase their knowledge of health issues, in caring for themselves and others, coping with health conditions, raising issues with health professionals, making treatment decisions, improving lifestyles, and understanding more about medications. Health professionals, including physicians, see HIRC as a beneficial service and a supportive link to facilitate client access to information. Community health organizations see HIRC as a complementary service which has the potential to promote their organizations. Finally, public and medical libraries are supportive of the Centre and regularly refer clients to HIC.

The coordinator for the Health Information Resource Centre has been involved in the planning, implementation and management phases of the Centre.

All Islanders can access the services available through the Centre. A number of satellite sites have been established to create local access to information. These sites were developed through partnerships with Regional Health Authorities, community organizations and the private sector. There are sites in Eastern Kings, Southern Kings, East Prince and West Prince (under development).

EASTERN KINGS HEART HEALTH PROJECT

PEI Heart Health Initiative, Prince Edward Island

INITIATIVE

The PEI Heart Health program is part of the Canadian Heart Health Initiative (CHHI). The Eastern Kings Project is the dissemination phase of the CHHIwhich began in April 1996.

LEADERSHIP

A research proposal was written for the National Health Research Development Program (NHRDP), which funded the project with support from the PEI Department of Health and Social Services, and the Eastern Kings Health Authority.

The Project was initiated by government employees. There was a staff of five, two of whom were hired from Eastern Kings. The Project was conceptualized as a community mobilizing project and was therefore ultimately driven by community volunteers.

There was a tremendous amount of commitment from the CEO and from public health nurses and community volunteers who have been involved in all aspects of research and program design and development.

NEEDS ASSESSMENT

A recent community survey was reviewed and heart disease was listed as a high priority for the community. Consultations were conducted with health system management and community representatives, as well as individual interviews with community stakeholders, to confirm the legitimacy of the Heart Health Project. Extensive baseline data was collected on the population's awareness, attitudes, behaviour and readiness to change vis-à-vis lifestyle risk behaviours for heart disease and cancer.

The survey (a representative sample of Eastern Kings residents) indicated that a majority of residents were aware of the links between lifestyle and health and were making efforts to modify their lifestyles; however, about one-quarter of the population had not tried to take responsibility for their health. The data indicated that, while approximately three quarters of the population were making efforts to maintain and/or improve their health, they have not met their health goals. There was strong support for environmental changes and clear evidence that information was not enough. People needed skills, support, and a healthy environment in order to achieve improved population health.

The survey data collected by trained community volunteers is now being translated into programs by the Healthy Communities In Action Group (a volunteer community group that has formed into lifestyle risk behaviour working groups and action committees).

GOALS

The overall goals of the Eastern Kings Heart Health Project were to mobilize the community around sustainable health promotion activities. The Healthy Communities In Action Group identified goals to increase community awareness, reduce smoking, increase physical activity, improve dietary habits and increase stress management, while promoting a healthier community environment.

PROCESS

A partnering and community mobilizing approach which involved broad community consultation, active involvement of community members, systems people and volunteers in all aspects of the Heart Health Project was used. The focus over the last year was on building awareness and trust among staff and volunteers.

ONGOING COMMITMENT AND LEADERSHIP

The Heart Health Project has enjoyed federal, provincial, regional and community support. The level of commitment has been high among all of these partners, with the level of involvement being highest among community members.

Community ownership of the process has been building and is currently very strong. Staff are also very committed to the principles and process of community mobilization and the goals of the East Kings Heart Health Project. The Eastern Kings Health Authority provides office space and a nurse three days a week. This position is viewed as an essential commitment to sustainability of the initiative.

Financial support is greatest from NHRDP, the province and the region.

MODEL/FRAMEWORK

The PEI Community Mobilization Framework was used.

EVALUATION

This is a dissemination research project. Therefore, evaluation is central to the project. Constant ongoing documentation and evaluation, both qualitative and quantitative, is carried out.

IN YOUR OPINION

In a general sense, we are learning that the principles of community mobilization, as outlined in the PEI Community Mobilization Framework, are effective in engaging a community in health promotion activities; however, it is premature to establish the particulars of our learning at this time.

Though all the data has not yet been analyzed, our day-to-day experience here in the community working with community and systems people has been very positive. There is a great deal of community ownership, skill building, and evidence of some behavioural changes among project champions and early adopters.

This project is organized into three phases:

☐ *Entry*

☐ *Community Organizing*

☐ *Implementation*

We are currently in the Community Organizing Phase. There are a growing number of active volunteers, both in research and programming, and increasing environmental and structural support for health promotion concepts and initiatives.

I wrote the proposal; however, the concepts for the PEI Community Mobilizing Framework arose out of the Demonstration Phase of the PEI Heart Health, a project which took place in Summerside, PEI. I have been central in facilitating its use through staff development and active community involvement. Heart Health staff work with the values and principles of the Framework, and community members are also integrating and exemplifying these principles. We will be directly involved with the community until April 2000.

The model is available to all who are involved in the Project and all who may be interested.

HIV AND SUBSTANCE USE

Community Health, St. John's Region, Newfoundland

INITIATIVE

In 1996 the theme of AIDS Awareness Week was HIV and substance use, and the desire of Community Health to work with youth.

LEADERSHIP

The Reproductive Health Coordinator took the lead and involved others in running the program. The type of leadership included managing the details and involving others in the process. The organization committed staff and time to work.

NEEDS ASSESSMENT

This was carried out informally by the consumer representatives on the organizing committee who fed back the solicited ideas from the target group. Target groups were professionals who worked with youth.

Follow-up with focus groups and evaluation with participants was carried out. The information gained one on one with the target population and from developing displays allowed the participants to become more comfortable discussing issues relating to sexuality.

GOALS

The goal was to target people who worked with youth, especially those youth who were outside the traditional school setting. Another goal was to expand the numbers of resource people (for example, teachers, youth leaders, and counsellors) who would be available to inform the general population about HIV.

r-3

PROCESS

The process involved a partnership between the AIDS committee and the alternative school.

A workshop format was chosen (first year 1.5 days, second year two days). In the first year a "train-the-trainer" format was used, which was not necessarily the best format. In the second year a more interactive working group/panel format was developed.

ONGOING COMMITMENT AND LEADERSHIP

Management provided full support. Staff were committed from two departments. Financial support was available through a federal grant. This grant money was also used to develop a resource manual on HIV and substance abuse. Other support came from volunteers with the AIDS committee.

MODEL/FRAMEWORK

To ensure that those who worked with youth had sufficient information, the staff developed a manual.

EVALUATION

Evaluation forms were provided and focus groups were subsequently held to assess impact and use.

It was established that there was a continued need for information about HIV. The coordinator and team recognized that a better mechanism to teach youth about HIV is needed.

IN YOUR OPINION

People want more information, so there are two more workshops planned for the winter. We need to consider how to reach people in rural areas who are most frequently volunteers in community health.

Challenges:

- ☐ *Getting people to come for two days (many are volunteers and cannot take the time away from their paid work)*
- ☐ *AIDS/ HIV is a value laden topic so we need to get people to recognize their own attitudes and judgements about it*
- ☐ *Making people comfortable with the topic of sexuality, sexual practice, etc.*

BABY'S COMING, BABY'S HOME: A SMOKING CESSATION PROGRAM

Community Health, St. John's Region, Newfoundland

INITIATIVE

The impetus for this program came from feedback from some clinics and staff that there were gaps in the Environmental Tobacco Smoke issue for the prenatal and postnatal periods.

The project was initiated in 1994 when funding was provided under the Tobacco Demand Reduction Strategy.

LEADERSHIP

Community Health and the Lung Association formed a partnership and invited colleagues to form an advisory committee. There was a strong commitment from and a high level of participation by organizations and interested parties involved in the partnership.

NEEDS ASSESSMENT

A needs assessment was part of the initial process and was conducted at two levels. 140 questionnaires were sent out, with a fifty percent response rate. Focus groups were organized, which included 23 physicians and 22 mothers. Prenatal and postnatal mothers and families and healthcare providers were assessed by the Baby's Coming, Baby's Home project. A gap was identified regarding materials for the environmental tobacco smoke issue in the prenatal and postnatal periods. This indicated that materials were needed for the families and for the health care providers to use.

GOALS

- ☐ Increase awareness of environmental tobacco smoke issues.
- ☐ Increase access to resources.

PROCESS

The team produced appropriate materials and provided training to those who would be using the resources. They also worked to increase the distribution of resources.

EVALUATION

There will be continuing promotion of the materials, distribution of the resources, and provision of training regarding use of the resources.

Community Health offices, the Lung Association, hospitals, colleges and fitness centres all have access to this information.

IN YOUR OPINION

In order to improve this program, we could narrow our focus and goals, workplan and objectives to keep us on track. It would also be useful to have better agreements and improve the understanding between partners regarding role and commitment of the organizations.

Challenges:

- ☐ *changeover in staff directly involved in the project and changeover in coordinators and evaluators working with the project*
- ☐ *differences in perspectives among advisory committee members, thus making it difficult to come to an agreement regarding the focus and philosophy of the project.*

MENOPAUSE/OSTEOPOROSIS FORUM

Community Health, St. John's Region, Newfoundland

INITIATIVE

The Reproductive Health Consultant (RHC) studied resource material linking osteoporosis and menopause and recognized there was a need for information about both.

The program was initiated in 1995.

LEADERSHIP

The consultant took the lead and involved others. The organization committed staff people and time to work.

NEEDS ASSESSMENT

The RHC knew there was little education available about menopause and osteoporosis, and had been receiving many requests by phone and mail for information about these topics. She used these requests to form the education process. Individual requests and literature from the Osteoporosis Society linking menopause and osteoporosis helped shape the forum. A forum on menopause and osteoporosis was seen as a route to deliver required information.

GOALS

The goals were to inform women about the actual process of menopause, to educate women on how to cope or deal with the process, and to educate them about the risks and links of osteoporosis with decreased hormones in order for them to make informed decisions about which course to take.

PROCESS

Partners who were interested in developing and participating in the forum were identified.

The snowball approach was used, where initial contacts advised the RHC of other agencies or groups who would be interested or had worked in this area.

ONGOING COMMITMENT AND LEADERSHIP

Management committed staff time, but no extra funding. Staff were used as presenters at the forum. Financial support came from charging a registration fee in order to pay for rental of the hall. The Milk Marketing Board donated milk products for the nutrition break.

MODEL/FRAMEWORK

Women needed to be educated and they needed information so they could make informed choices. It was important to make the link between health and lifestyle choices.

EVALUATION

The first forum provided an evaluation form. Women were asked about their needs at the beginning of the sessions and reviewed them at the end of the day.

The second forum had a research component in which a questionnaire was administered at the beginning of the day about known information, and a second one was administered at the end of the day with respect to lifestyle. A third will be sent out in six months to assess lifestyle information retained. Another forum is planned for next fall. The information need is still there (capacity for the workshop is 100 participants). The Chair of the committee coordinated the planning and follow-up, acted as the resource person, and looked after details.

The process/agenda is available to anyone who wants it. Background material is also available. The Committee will probably do more about forming support groups relating to menopause and osteoporosis.

IN YOUR OPINION

Concurrent session format would be considered, as people wanted all the information, not just some, and the choice of resource people would be reviewed.

Challenges:

- ☐ *participation from committee members*
- ☐ *people who presented poor information that non-constructively challenged traditional medical practice*
- ☐ *ensuring that participants obtained good information on which to make decisions*

YOUR HEALTH, COMMUNITY HEALTH: CABLE PROJECT

Community Health, St. John's Region, Newfoundland

INITIATIVE

The idea for a cable television series about community health originated from the Communications Manager. It was initiated in the fall of 1996.

LEADERSHIP

The Manager for Health Promotion and the Executive Director of Community Health made the series a priority.

They committed to employing a Population Health Consultant who started at Community Health in January 1997 and coordinated the production of the television series.

NEEDS ASSESSMENT

In January 1997 a memo was sent to all staff asking for their suggestions on the priorities the program should cover. This needs assessment was used to develop the project and to define what kind of model to use (interactive, consultative or participatory).

Priorities were established in what would be covered in the series. Items were grouped by topic and a variety of ideas were introduced in two different formats (interview preceded by a video segment). Staff were involved in the process, and those who responded felt some ownership and continued to inquire about the progress of the project through its duration.

It was hoped to address the determinants of health and discuss health promotion. The project would fall in health promotion and assist in creating public awareness of the mandate and services (health promotion, health protection, mental health, addictions, and continuing care). There are six half-hour programs that cover the age span and the interdisciplinary nature of Community Health.

GOALS

- ☐ Be clear about the work.
- ☐ Stand out from the usual cable television programming.
- ☐ Involve staff in the shaping of the project.

PROCESS

After the needs assessment, the Population Health Consultant prepared a draft outline for each program and circulated it for additional feedback. The decision was to develop video segments to introduce the interviews with Community Health staff and, when required, to develop scripts, host the series, identify actors, and interview subjects to establish a shooting and editing schedule. The education tools used were video segments and interviews.

ONGOING COMMITMENT AND LEADERSHIP

Management was very supportive, committed staff time and encouraged staff to participate as interviewees and actors on worktime.

Staff were very interested. They liked being asked for ideas about content, were very helpful in identifying people to act as interview subjects and gladly participated in taping the segments.

With the exception of funding for a coordinator, there was no additional financing, as this was a joint project between Community Health and Cable (a community channel for which filming is done by volunteers). A retired broadcaster volunteered his time as host and interviewer for the series.

MODEL/FRAMEWORK

The project was to involve as many people as possible, such as actors, writers and consultants. Staff felt they had contributed to the series, and their contribution was driven by what they understood from their clients to be the most important information needed about Community Health.

The focus of the project can be described as participatory and flexible. The process is quite comprehensive, with an emphasis on nurses, physiotherapists, occupational therapists, social workers, counselors, and other healthcare workers represented in the programs.

EVALUATION

There has been no formal evaluation to date. An informal evaluation of this project is planned.

IN YOUR OPINION

We have learned how important it is to involve people, take their ideas seriously and let creativity happen.

Based on my perceptions of this project, I think it was a success. The responses and feedback to date have been very positive. We have had several requests for copies of the programs, which we hope to use as a teaching tool. I solicited feedback, collated suggestions, developed the outline, wrote the scripts, lined up the interviews and actors, developed short lists, went on video shoots, assisted in editing and organized promotion and publicity for the series, including a program guide.

The series is available on tape to anyone who wants to see it.

I did not have a budget and there were some things we needed to pay for, such as the brochure. We also wanted to give some honoraria and make copies of the tape.

The biggest hurdle was making people feel comfortable about the camera.

HEART SMART RESTAURANT PROGRAM

Community Health, St. John's Region, Newfoundland

INITIATIVE

Heart Smart was an educational initiative designed by the Heart and Stroke Foundation of Canada. In St. John's and Mount Pearl, Heart Smart was sponsored by the St. John's and District Health Unit, the Heart and Stroke Foundation of Newfoundland and Labrador, and the Restaurant and Food Services Association, with the support of Hospitality Newfoundland and Labrador. The program was funded by the Newfoundland Heart Health Program.

GOALS

The aim of the Heart Smart Restaurant Program was to encourage people to make healthy choices when they eat out and to encourage restaurants to provide these alternatives.

The criteria for the program plans were established by the Heart and Stroke Foundation of Canada in conjunction with their provincial offices throughout the country. The criteria were based on Canada's Guidelines for Healthy Eating, which form the basis for the new Canada's Food Guide. The criteria were designed to address broad health and lifestyle issues, and were in keeping with the recommendations of many other health care agencies.

There were two options available to restaurants:

☐ **The Choices Program**
The Choices Program was the program promoted in Newfoundland. In order to participate in the program, food service establishments had to agree to meet a set of preparation, serving and no-smoking seating criteria. These criteria were designed to determine a restaurant's willingness to provide healthy choices to their customers.

The Heart Smart Restaurant Program emphasized choice. The program was consumer-driven, meaning it was up to the consumer to request the choices made available and to choose to eat well.

To help the customer make healthy choices, information was placed on table tents, menu inserts, posters or place mats which the participating establishments agreed to use to promote the program. In addition, all participating restaurants offered no-smoking seating on request. The establishments participating in the Heart Smart Restaurant Program were identified by a Heart Smart logo on their front door or window.

The program was flexible, easily adapted to a wide variety of eating establishments, and available to all establishments that met the criteria. Restaurants that did not meet the choices criteria had another option, the Menu Program.

☐ **The Menu Program**

With the Menu Program option, restaurants submitted specific menu items for analysis. Recipes that met criteria for salt and fat content, set by the Heart and Stroke Foundation, were then identified by a small red check mark on the menu. Restaurants make the complete nutritional analysis of these selected menu items available at the request of their customers. Restaurants that opted for the Menu Program did not need to complete the criteria form of the Choices Program.

For the Menu Program, restaurants may be asked to pay for recipe analysis. The Heart Smart Advisory Committee is currently investigating this issue and it is hoped that the recipe analysis can be provided for low or no cost in the future.

Restaurant Involvement

The restaurant agreed to meet the criteria while involved in the program. The restaurant used promotional material to alert customers to the fact that they were participating in the program. Restaurants were also involved in promotional activities undertaken on behalf of the program throughout Heart Month (February).

PROCESS

Invitations to participate in the program were sent out to restaurant owners, including an introductory package to the program. Each restaurant had to meet certain criteria to participate in the program, including designating a non-smoking area with a sign, and nine criteria for healthy food choices; for example, having whole wheat breads available and giving diners the choice of having dressings and sauces on the side. The introductory package included a list of questions to which the restaurant owner responded either "yes" or "no." When the forms were returned to the Heart Smart Advisory Committee, they were reviewed and restaurants that responded "no" to questions were followed up to see if their answers could be changed to the affirmative. If approved for the program, the Committee sent the restaurant a package which included posters, table tents, menu inserts and a door decal which designated the restaurant as a "Heart Smart" participant.

EVALUATION

Several surveys of customers have been distributed through participating restaurants. Restaurants are visited on an annual basis to conduct a short survey with the owner. Responses to this program have generally been positive. The impression of restaurant owners is that there is an indication of an increasing number of customers requesting healthy choices when ordering food.

One challenge is insufficient money to advertise participating restaurants. Although the program may not be widely known, those restaurants involved are positive about it. It is difficult to know whether people frequent a particular restaurant due to the program or whether this program is contributing to decreasing heart disease.

MENTAL HEALTH CRISIS CENTRE

Community Health, St. John's Region, Newfoundland

INITIATIVE

The Mental Health Crisis Centre, a 24-hour crisis intervention project, was developed in response to the need for such a service. The need was identified by consumers of mental health services.

LEADERSHIP

Community Health, St. John's Region, in partnership with the Health Care Corporation and the Provincial Department of Health, established the program. A community-based implementation committee established the project. Commitment from the partners for physical space, heat and light, telephone and human resources was most important. A strong commitment from all participants was apparent.

NEEDS ASSESSMENT

The needs assessment was completed in 1994, with key stakeholders attending a follow-up meeting in mid-1995. The outcome of the needs assessment was a need for 24-hour crisis service.

GOALS

The goal is to provide telephone and face-to-face crisis interventions and triage in mental health crises outside the normal 9-5 workday.

PROCESS

Implementation involved partnering and linking with key stakeholders in the region. Focus groups with consumers, stakeholders and partners were held over a six- to eight-month period.

MODEL/FRAMEWORK

The model was client-centered and consumer-driven using a unique blend of paid and volunteer staff. The focus was to provide crisis intervention by telephone or in person.

EVALUATION

An external evaluation is currently underway. A consulting firm is being used to conduct interviews and focus groups with clients and stakeholders and with consumers regarding client satisfaction.

Clients have indicated that they received the help they needed when they needed it.

The challenges encountered have included obtaining long-term financial commitment from partners and consumer participation.

LUTSELK'E FAMILY LEARNING CENTRE

Lutsel K'e First Nations, Northwest Territories

INITIATIVE

The initiative was to establish a Family Learning Centre. The program components included:

- ☐ Child Development/Mental Health Promotion
- ☐ Child Health
- ☐ Injury Prevention
- ☐ Parenting

LEADERSHIP

The programming for the Family Learning Centre was planned in conjunction with the Band Council and the Community Drug and Alcohol Coordinator, the RCMP, the adult educator and the Health Centre.

PROCESS

The Family Learning Centre began late in the 1994/95 fiscal year and focused on the establishment of the centre, purchasing resources and the planning of activities and programs. The centre officially opened in October 1995. In its first year of operation, a feast was held to introduce the centre, and offered cultural and recreational programming with one First Aid/CPR course enabling eight people to obtain their certificates. Other programs which were established were a Mums and Tots program, a single parents group and an after school program with arts, crafts and games.

In 1997 a Coordinator of the Family Learning Centre was hired to deliver daily programming for elders, youth, parents and their children, and offer workshops and discussions on career days, wellness talks, health issues and talking circles. Elders participate in discussions on such topics as traditional childrearing methods, handicrafts, and traditional songs and dances. Workshops have also been organized and delivered on such topics as parenting and health, with good participation. Training has been offered to community residents on Fetal Alcohol Syndrome (FAS) so they could learn new ways to educate people regarding the effects of alcohol on their unborn children.

In December, the Family Learning Centre was asked to organize alcohol-free holiday activities. As a result, several special projects were held for the whole community. A Chipewyan fiddler from Fond-Du-Lac was brought in to play at alcohol-free dances over the holiday period, with good community participation. A Santa stand was set up so children could visit Santa and the coordinator worked with the Salvation Army and the Yellowknife Correctional Institute to provide toys and food hampers to low-income families at the Christmas concert.

The centre also organizes off-site programming to teach youth survival skills on the land, to discuss how drugs and alcohol affect their lives and to reinforce the importance of education.

ONGOING COMMITMENT AND LEADERSHIP

This is the second year of the Family Learning Centre. The community plans to continue this program.

EVALUATION

IMPACT OF THE PROJECT

The community feels that the programs that have proven to be the most successful are the traditional programs, where elders teach the younger generations about traditional knowledge, values and skills. The band council also feels that the Family Learning Centre has brought the community together and increased communication between the generations. The community has also started to integrate the local wellness programs.

- ☐ Strengths: The Family Learning Centre has established a program for all ages in the community. There is strong community and interagency support.
- ☐ Weaknesses: The Family Learning Centre programming may be too broad and may be trying to serve too many groups in the community. There are indications that the programming may be more focused in the future.
- ☐ Gaps: The Family Learning Centre could be making more linkages with the school to integrate their programming.

BRIGHTER FUTURES: BUILDING HEALTHY COMMUNITIES

Indian Health Services Regions, Northwest Territories

INITIATIVES

I. BUILDING HEALTHY COMMUNITIES

The initiatives focus on:

- ☐ parenting skills
- ☐ child health (healthy babies)
- ☐ mental health promotion and child development

II. BRIGHTER FUTURES CENTRE

- ☐ Name of community/organization: Hamlet of Kugluktuk, Kugluktuk (formerly Coppermine), NT
- ☐ Program component: Child Development/Mental Health Promotion; Parenting
- ☐ Project duration: This is the second year of the program. The intention is to continue.
- ☐ Budget (all sources): The community's total allocation is $144,000. The Brighter Futures Centre utilizes $87,000.

I. BUILDING HEALTHY COMMUNITIES

PROCESS

- ☐ Parenting skills projects include:
  - Parenting component at the Family Support Centre (Baker Lake)
  - Adult literacy program with regular courses on child care and parenting (Jean Marie River)
  - Workshop to help parents learn to cope with parent/child conflict (Rae)
  - Parenting skills workshop to teach young moms about Fetal Alcohol Syndrome (FAS) and other issues (Sanikiluaq)

- Training for foster parents to improve skills in working with foster children and their biological families (Fort Simpson)
- Home visits to provide support and identify parenting issues (Yellowknife)

☐ Child health (healthy babies) projects include:

- Workshop on "Being Young Mothers & Feeling Healthy" (Lutsel K'e)
- Workshop on FAS (Rankin Inlet)
- Two individuals were sponsored to a workshop on FAS (to learn new ways to educate people on the effects of alcohol on unborn children). These individuals will become the community resources on FAS (Lutsel K'e).

☐ Mental health promotion/child development projects include:

- Inuuqatigiit Program: Elders come to Inuglak School to share traditional knowledge and skills (Whale Cover)
- Kicking Caribou Theatre Company at the Innujaq School writes and presents plays about issues relevant to the community. This year, the students wrote "What's the Matter, Mary-Jane?" which deals with a young teenager who is trying to make the right choices at a time when everything seems to be going wrong (Arctic Bay)
- Assisting students with learning problems (Chesterfield Inlet)
- Youth Peer Counseling Training (Repulse Bay)
- Short- and long-term counseling for children and adults who have disclosed child sexual abuse (Iqaluit)
- Suicide Prevention Workshop (Broughton Island)
- Moms and Tots Program (Deline)
- Small Steps - early intervention to prepare dysfunctional preschool children for school (Arviat)

☐ Injury Prevention Projects include:

- Cultural Group where youth were also taught water, fire and gun safety (Fort Simpson)
- Gun, skidoo, canoe, boat, chainsaw, axe, and ATV safety (Trout Lake)

- Net setting, shelter making and other survival skills for Junior Rangers (Paulatuk)
- Crossing Guard Program run by students from the Grade Six class, helping the younger students cross the road safely (Repulse Bay)
- Sponsorship of an individual for training in First Aid and CPR. This individual completed an instructor's course and will provide training in the community (Fort Providence)

EVALUATION

Community-based, culturally appropriate projects and programs are developing. Training and educational workshops have been delivered to raise awareness and skill levels at the community level. Many community programs started with general programming but are moving toward formal and focused programming, especially as staff gain confidence, knowledge and experience. An unexpected spin-off is that community members are holding their hamlet or band councils accountable for Brighter Futures funding and programming. An example is Fort Good Hope where elders worked with youth to ensure the transmission of traditional knowledge and values as well as bush survival skills. At a community meeting recently, community members requested an evaluation of the program. In response to concerns, goals and objectives were clearly defined and students participating in the project will meet with a selection committee.

STRENGTHS

The integration of Brighter Futures and Building Healthy Communities has made it easier for communities to focus on program development and implementation. Communities have commented that the integrated funding has allowed them to focus on program development rather than writing proposals and fulfilling reporting requirements.

The developmental aspect of Brighter Futures gives the community time to develop programs at their own pace. Many communities have progressed markedly in the type of programs they are operating and have had the opportunity to learn from their mistakes without having their funding levels compromised.

A Community Wellness Newsletter relates the success stories of community projects funded by Brighter Futures/Building Healthy Communities and CPNP-FNTC. This has helped to share ideas and promote the "wellness" funding programs.

WEAKNESSES

Most communities still have a tendency to run "short-term" projects; however, many communities which are now running continuous programming were focused on short-term projects in previous years.

Many communities have commented that more user-friendly resources on topics such as Fetal Alcohol Syndrome, parenting, child development, suicide prevention, and other social issues are required.

GAPS

Many small communities lack appropriate facilities to deliver their programs, but Brighter Futures/Building Healthy Communities cannot be used for capital expenditure. This has created a problem for some communities where planned programs have been limited because there wasn't an appropriate facility to deliver the program.

In the NWT there are only two reserves. The majority of aboriginal people live in communities across the NWT. In the western Arctic, Metis live in communities side by side with aboriginal people. Metis are not represented by the local band council but often face the same health and social issues as their aboriginal neighbors. Directing the funding solely to First Nations without addressing the needs of Metis living in the same community can be divisive.

ALTERNATIVES

A discretionary capital fund that could be used by these communities would be very helpful. Perhaps a percentage of the community's allocation could be used for capital for a program which meets Brighter Futures criteria. A separate funding program may solve the problem, but in many ways creates a new one, as communities would once again have to submit separate applications.

In the NWT, Brighter Futures and Building Healthy Communities have been integrated. Funding is provided to communities using the Brighter Futures guidelines. The integration has made it much easier for communities to devote time and energy to program development rather than writing proposals and reports.

There are a significant number of other Health Canada "wellness" funding programs which are administered by Health Promotion and Programs Branch through the Alberta offices of Health Canada. Examples include Aboriginal Head Start, Canada Prenatal Nutrition Program, Community Action Program for Children. Communities have asked for "one window shopping" in order to eliminate obvious gaps and duplication of programming. This is particularly important when administering resources for remote northern communities. Integration of all "wellness" funding in the NWT would also make it easier to assist communities in developing an integrated approach to wellness programming to create partnerships and lessen confusion at the community level.

II. BRIGHTER FUTURES CENTRE

LEADERSHIP

The partners include: community health representative (Health Centre), mental health specialist (Health and Social Services), regional health promotion officer (Kitikmeot Health Board), Jimmy Hikok Iiihakvik (elementary school), Kugluktuk High School, Elders Centre; Prenatal Nutrition Program Coordinator, Home Care Coordinator, Kugluktuk Women's Group, Youth Group.

GOALS

The Brighter Futures Centre focuses on teaching children traditional knowledge, values and skills (i.e. carving, sewing, and hide preparation). The Coordinator of the program has established a regular program schedule.

PROCESS

During the school year, classes from both schools come in on a regular basis. Two elders assist in the teaching of traditional knowledge, values and skills. Classes are conducted in Innuinaqtun to help preserve and promote the use of their language. Emphasis is on students familiarizing themselves with their culture, thereby gaining self-awareness and self-esteem. During the summer the program operates on a drop-in basis.

For the first year the program was limited; however, it expanded in its second year to include workshops on suicide prevention, parenting, alcohol and drug awareness. The Coordinator also works with a youth coordinator to develop and implement recreational activities for youth. She has also started a culturally adapted Brownies/Guides program and has been involved in securing and training leaders for each group. She is also closely involved in the establishment of a prenatal nutrition program (funded by CPNP-FNTC) in Kugluktuk.

EVALUATION

The Coordinator has succeeded in establishing classes which are integrated into both schools and involve local elders. There have been spin-off projects which have started as a result of her work, such as the prenatal nutrition project and the Brownies/Guides. Many community members also feel that the program has helped to increase communication between the elders and the youth.

STRENGTHS

The community has hired a very strong Coordinator who speaks Innuinaqtun and English fluently and is well respected in the community. There is strong community and interagency support and the program appeals to a wide variety of ages and integrates aspects such as parenting into the school programs.

WEAKNESSES

It is possible that the Coordinator's duties are expanding beyond one position. There are so many spin-offs from the Brighter Futures Centre that the Coordinator is at risk of becoming "burned out."

GAPS

In the first year there was a gap as the program focused solely on children and youth. There were no educational workshops for the other members of the family. At the end of the first year, the Coordinator conducted a survey to evaluate the program and to help plan programs for the new year. Based on the responses, workshops on suicide prevention, parenting, alcohol and drug awareness were implemented.

EDUCATIONAL INSTITUTIONS

CASE STUDIES

WELLNESS PROGRAM

Red River College Wellness Committee, Manitoba

COMPREHENSIVE SCHOOL HEALTH

Eastern School District, Prince Edward Island

WELLNESS PROGRAM

Red River College Wellness Committee, Manitoba

INITIATIVE AND INITIAL LEADERSHIP

The health programs and awareness campaigns from the College Health Centre were started about ten years ago because a need was identified. Seven years ago the Manitoba Cancer Society sponsored a committee which developed a package for implementing Wellness programming into business. The package was presented to the College Management Committee at Red River Community College at that time and received their approval to proceed with its implementation.

About three years ago, a half-time paid position was created for a "Wellness Coordinator."

NEEDS ASSESSMENT

Needs assessments were conducted in 1990 and 1996. The 1990 assessment surveyed staff only. In 1996 315 students and 100 staff were surveyed. Due to the format of the survey method, well over 90 percent of student surveys were returned, and about 60 percent of the staff surveys.

The surveys established:

☐ the educational presentations people would like
☐ the programs people were interested in
☐ feedback on existing programs and facilities at the College
☐ a willingness to pay a nominal fee for the services offered by Recreation Services

The results of the 1996 Survey of Educational Topics indicated that 86 percent of students and 87 percent of staff were interested in educational presentations.

The most popular topics were:

☐ Stress Management
☐ Weight Management

☐ Nutrition Issues
☐ Exercise for Health
☐ Back Care
☐ Time Management
☐ Body Image
☐ Heart Health

Survey results also indicated that 91 percent of students and of staff were interested in participating in a variety of programs or classes.

The most popular topics were:
☐ Self Defense
☐ Strength Training for Beginners
☐ Running Programs
☐ Stretch and Relax Classes
☐ Walking Programs

The results of the needs assessment were used to help plan the activities of the Wellness Committee.

GOALS

The Mission Statement of the Wellness Committee was *"to promote Wellness to all Red River Community College students and staff through education, programming, and policy development."*

The Committee's definition of Wellness was *"the integration of body, mind and spirit – the appreciation that everything you do, and think, and feel, and believe has an impact on your state of health."*

Objectives of the Wellness Program were:
☐ Provide education and awareness of Wellness issues through:
  - publication of the "Wellness Program Newsletter"
  - relevant articles in other College publications (student paper, staff newsletter)
  - free informational pamphlets (available at the Health Centre)
  - display windows and bulletin boards
  - display booths promoting appropriate topics
  - use of community fitness and health agencies, programs and personnel

☐ Provide programs which promote physical, mental and spiritual well-being.

☐ Recommend and implement policy which will provide individuals with the opportunity and the environment necessary to pursue wellness.

PROCESS

Committee members or other "experts" wrote articles for College publications. Two display cases in high-traffic areas of the College were updated and changed regularly. Presentations were made every month.

ONGOING COMMITMENT AND LEADERSHIP AND MODEL/FRAMEWORK

The committee was composed of staff and students at the College. Members of the committee were volunteers recruited due to their area of specialization or their enthusiasm to be involved, and met monthly. The Coordinator and Director met weekly.

Originally management support was poor; however, when a new president arrived, there was much greater support.

The committee had a budget of only $500 per year. Monies from either the Health Centre or Recreation Services budget sometimes subsidized this.

EVALUATION

There has been little concentration on programming and policy; however, this year, in conjunction with the Education Support Centre, workshops were held to assist mature students with the stresses of writing exams.

IN YOUR OPINION

This survey was answered from the perspective of the Red River College Wellness Committee. It should be noted that the Health Centre at the College also offers a variety of services to students and staff in the area of workplace health and wellness. Recreation Services also offers facilities and programs and services to the population at the College. Speaking on behalf of Recreation Services, we have seen an increase in usage of the facilities from last year as well as an increase in enrollment in our programs. This is probably attributed to better marketing and the timely purchase of some new equipment. I know that some of our increase in usage is also due to talks that I have given in different classes, but I could not possibly estimate exact numbers.

One of the problems encountered in our situation is the fact that programs at the College tend to be 1-2 years in duration. There are also several apprenticeship programs which only last 6-8 weeks. The programs here are quite time intensive. Many students attend classes all day with only a one-hour break for lunch; then they must rush off to their part-time jobs or back to their families. The 'geography' of the College is also somewhat of a barrier. Just letting people know about what is being offered and when is always challenging. We are still trying to find effective ways to reach more students and staff.

I think that one of the pluses for us is that our committee is relatively small and independent. Therefore, it is easy for us to react quickly and to make changes as we see fit. If we see that something is not effective, we can change it almost immediately and try a new course of action. This, in part, will ensure our success in the future.

COMPREHENSIVE SCHOOL HEALTH

Montague Consolidated School, Prince Edward Island

INITIATIVE

In October 1995 local and provincial levels of the Health and Education systems of Prince Edward Island met to discuss strengthening services for children with special needs at Montague Consolidated School. A more collaborative approach to better meet the needs of those children was sought. Discussions followed for more coordination between Education and Health in order for all children to be better able to learn because education is one of the key determinants of health. The discussions were influenced by the following:

☐ A School Health Team was initiated at Montague High School in February 1995.

☐ The Southern Kings Health Authority, formed in 1994, was committed to developing community partnerships and believed that the education of children and their families was important to their physical, mental, social and spiritual health.

☐ The Health and Education systems knew that overall health is determined by physical conditions of the home, school and the community, income, employment and working conditions, education, healthy child development, access to health services, personal health practices and coping skills, social support networks, genetics, gender, and culture.

In September 1996 the spirit of the developing partnership was shown when a Memorandum of Understanding was signed between the Director of Community Services on behalf of Southern Kings Health and the Principal of Montague Consolidated School to employ a social worker one day a week at the school. This partnership was a first for the Province of PEI, and positive results are already apparent in the areas of prevention and early intervention.

LEADERSHIP

In the fall of 1996 a broad community-based Steering Committee was established to provide direction for the pilot project at Montague Consolidated. The Steering Committee representatives included the school principal, the school guidance counselor, the school health coordinator, a school council member (parents), a community representative and member of the school LOVE program, with the past school principal as chairperson. Other members included the director of Community Services, the supervisor of Child and Family Services Support Team for Southern Kings Health, an RCMP representative, a spiritual community representative, a community-based worker from the Carousel Family Resource Centre, and the Montague Town Council represented by Partners for Living.

The Steering Committee was committed to establishing the partnerships required to effectively implement the Comprehensive School Health Model in the school; to create awareness among children, parents, teachers, and the broader community of the goals of Comprehensive School Health; and to develop a continuum of services and approaches as children move from early childhood to Montague Consolidated School and then to junior and senior high school.

The Steering Committee's mandate was to develop, facilitate, implement and evaluate the Comprehensive School Health Model in the school. To meet this mandate, the objectives were:

☐ Identify priority health needs of children in the school.

☐ Develop a work plan which will include activities, specific actions and events designed to address the priority health needs.

☐ Establish the evaluation mechanisms to determine if results are being achieved.

☐ Establish appropriate linkages with other agencies, community groups, businesses or individuals to assist in addressing the health of children.

☐ Establish appropriate linkages and referral mechanisms to support services available in the community.

☐ Critically evaluate public policy, which may be having a negative impact on the health of children and lobby for required changes.

☐ Establish a clean, safe physical environment which prevents injury and disease, and which facilitates healthy behaviour.

PURPOSE, GOALS AND OBJECTIVES

The purpose of the project was to enable children to be better able to learn, with the understanding that education is a key determinant of health.

The goals were:

☐ Strengthen relationships with the educational system, the health system, community leaders and families in Southern Kings in order for children to be better able to learn.

☐ Establish and encourage the skills, knowledge, attitudes and behaviours both within the school, the health system and the community that will help to support children's learning.

☐ Consistently encourage and support children to develop competency and confidence in their own abilities.

NEEDS ASSESSMENT

One of the first tasks of the Comprehensive School Health Project was to complete a needs assessment to identify the health issues at the School. The assessment was done with the emphasis on identifying the many positive activities and programs and building on these capacities or assets. The school health needs were identified after consultation with teachers, parents and feedback from the Student's Council—they all have equal weight:

☐ Nutrition
☐ Parents as partners
☐ Mental health
☐ Social health
☐ Physical health
☐ Physical environment

PROCESS

The process used to identify the health needs at the school encompassed review of articles, reports, past surveys and questionnaires, utilizing the Internet; identifying the resources, projects and programs in the community and at the school; consultations with teachers, children, parents, school support staff, community organizations/associations, volunteers, regional health authorities, Steering Committee members,

EVALUATION

LESSONS LEARNED

☐ **Partnerships**

Essential component for building partnerships are:

- Share the vision.
- Understand project's purpose, goals and objectives.
- Communicate among all participants frequently.
- Understand roles and responsibility of all group members outside the partnership.
- Address External restraints such as time, policies and funding.
- Recognize that professionals and volunteers may have different priorities and time constraints.

☐ **Cost effectiveness**

Factors to consider are:

- Prevention, early intervention and health promotion can save money by reducing related health costs.
- An integrated, comprehensive approach is more effective than fragmented programs.
- School is an excellent place to reach all children.

☐ **Flexibility**

The Comprehensive School Health model is flexible enough to adapt to all priority health needs. The steps include:

- Understand the goals of the Comprehensive School Health Project and the determinants of health.
- Identify the health needs.
- Build on existing programs and resources, as well as establish new activities and programs.
- Establish linkages with existing programs, activities, or resources in the school, health system and the community.
- Involve children, families and teachers in developing, implementing and evaluating all programs. Strengthen the support networks of children and their families.
- Develop resources and programs to support teachers.

☐ Criteria for Change

For change to take place the following elements are needed:

- There needs to be a common vision by all participants.
- People need the appropriate skills.
- Resources must be available.
- The Action Plan must be in place.
- There must be some incentive for people to be involved.

SUMMARY

SECTION THREE

These times of rapid change and shrinking resources call for action on all fronts by governments, businesses and communities working together to create living and working conditions supportive of health in homes, schools, workplaces and the community at large.

—National Forum on Health 1997

KEY CONCEPTS

There have been several significant milestones that led to the present philosophical approach to health promotion. The Lalonde Report, the Epp Report, the Ottawa Charter, and the National Forum on Health, sketch the evolution of health promotion.

Key concepts and prominent features discussed in the literature include an expansion of the definition of health and its determinants to encompass the social and economic context. These include moving beyond the earlier emphasis on individual lifestyle strategies to achieve health, to broader social and political strategies. These emphasize that improvement in the health of individuals may require changing the social and economic conditions in which people live.

The concept of empowerment, both individual and collective, is identified as a key health promotion strategy. In fact, it is suggested that empowerment represents a primary criterion for identifying health promotion initiatives, and some authorities suggest that an initiative can be classified as a health promotion initiative only if it involves the process of enabling individuals or communities.

A related concept is the advocating of community participation in needs assessment and the identification of strategies for addressing problems.

The concept of "settings" is fundamental to theory and practice in health promotion. It delineates boundaries of target populations, and provides the context in which health is influenced. The settings approach focuses on a particular setting such as school, workplace, or the community.

Thus today for individuals and communities, there is developing an expanded concept of health as an important part of everyday living, an essential dimension of the quality of life—a " basic and dynamic force" in daily lives—influenced by circumstances, beliefs, culture, and social, economic and physical environments.

THE WORKPLACE SETTING

The literature recommends that for health promotion to improve in effectiveness, professionals must adopt a more balanced approach and direction to programming that includes individual responsibility and health behaviours, and addresses psychosocial and socio-ecological issues—namely the work people do and the cultural context in which it is done. A workplace that consists of a culture that values worker health and psychological needs will increase the potential for improved well-being and increased productivity.

New strategies are needed to reduce the human and economic burden of workplace illness and injury. Suggestions for health promotion professionals include:

- ☐ Assessing work culture and its impact on stress and health; identifying high-risk areas, departments, and jobs for intervention
- ☐ Providing organizational change strategies such as communication and problem-solving training, job redesign, and participatory decision-making approaches
- ☐ Providing educational workshops and skill training that impact management practices, work conditions, and stress, and expertise on how to modify jobs so that they are less stressful

THE COMMUNITY SETTING

"Community" may encompass a neighbourhood or a municipality. It may also encompass varous groups conducive to common interpersonal relationships, such as schools, workplaces and social organizations. "Community" can be seen as encompassing many settings, while also having unique features of its own as a setting for health promotion.

The Determinants of Health Working Group Report of the National Forum emphasizes that not only medical interventions, but also non-medical interventions, can significantly assist a community in regaining, maintaining or enhancing the health of that community.

A basic "community" or "society" is the family. Support for families; assistance in parenting; a variety of non-medical interventions, be it improved housing, schooling, or other assistance, increases the likelihood of a healthy family and the raising of healthy children.

THE CASE STUDIES

A RESOURCE

The invitation to practitioners working in different settings across Canada to take part in the effort to expand the knowledge base, and to communicate what they learn to others in the field, has resulted in a new resource.

The collection of case studies, from a range of workplace and community settings, illustrates significant examples of current initiatives.

In a very practical way the stories of these organizations, the discussion of their learning, the articulation of the current challenges and frustrations, and most importantly, their successes, provide opportunities for insights and new learning.

These case studies provide examples from across the country, "snapshots" of wellness programs underway in a variety of settings. From the community health initiatives in St. John's, Newfoundland, to the corporate workplace of BC Tel; from the education initiatives in the Northwest Territories to the Wellness Mobile in Saskatchewan.

The application of key concepts and current themes from the literature, as well as ideas from the Health, Work, and Wellness Conference 97, is evident. Although the initiatives were diverse and the processes varied, several significant themes were reiterated throughout the case studies. These included needs assessment, commitment of leadership, cultural and organizational change, empowerment, partnerships and collaborations.

Needs Assessment

The case study from NBTel shows that a particular need, once identified, sparked what eventually became a very comprehensive program that influenced employees throughout the province. Consultative services were provided by the New Brunswick Heart and Stroke Foundation.

Commitment of Leadership

The commitment to wellness initiatives is illustrated in the varied examples from health care institutions: the specialized wellness caregiver program at Casey House Hospice, the program for long term care staff at Sherbrooke Community Centre, and the Wellness Works program serving the quaduciary Vancouver Hospital and Health Sciences Centre.

Cultural and Organizational Change

The Workplace Sanctuary model applied in a number of Montreal worksites is an example of an approach which gives much attention to organizational culture, as does the Workplace Health Promotion initiative of the Healthcare Benefit Trust.

Empowerment

The focus on empowerment was evident throughout the case studies. The educational initiatives described by the Wellness Program at the Red River College in Manitoba and the Community Vocational Alternatives program provided by Challenge and the Yukon College are two diverse examples.

Partnerships and Collaborations

The theme of partnership and collaboration is exemplified in the Shifting to Wellness programs. The Aspen Region of Northern Alberta identified the significant challenge of shiftwork in the region, and partnered with Keyano College with its considerable work in the development of training and support programs for workers and families. The RCMP Detachment within that same region developed a comprehensive program which included the shiftwork resources.

The Centre for Work and Health had the ultimate goal of providing expertise to Nova Scotian industries in the development of health and productive workplaces. A successful partnership was built between Dalhousie University and a private physiotherapy firm to maximize resources and build a unique service.

The Comprehensive School Health program initiative of the Montague Consolidated School in Prince Edward Island aimed to strengthen relationships within the school system, the health system, community leaders and families.

The support of volunteers was evident in several of the initiatives. In particular, the Cable Project: Your Health, Community Health, of St. John's Region Community Health was primarily developed by volunteer community support.

FUTURE DIRECTIONS

The work of establishing healthy settings may benefit from the extensive work underway in the field of quality improvement (Health Canada 1996).

The components of continuous quality improvement in an organization include leadership, education, corporate culture, teams and partnerships (Health Canada 1993, Wilson 1992, Scholtes 1988). These components are essential to "reshaping an organization". The movement toward continuous quality improvement starts with the uncompromising commitment of the senior leaders (Hassen 1991).

> *Leaders at every level find their greatest leverage of influence as mentors and models of the principles of the mission statement.*
>
> —Covey 1991

The literature on leadership purports that the practices of leaders today incorporate the following attributes: challenge the process, inspire a shared vision, enable others to act, model the way, and encourage the heart (Carlow and Harrigan 1998). Organizations of the future "must be mission-focused, values-based, and demographics-driven"(Hesselbein 1997).

In leading change, one needs to think about how we learn, what we learn, and what is our commitment to act (De Porter 1997). Key principles and concepts of adult learning optimize the learning experience, and enhance learning organizations (Jarvis 1995).

> *The organizations that will truly excel in the future will be the organizations that discover how to tap people's commitment and capacity to learn at all levels in an organization.*
>
> —Senge 1990

CONCLUSION

The focus of the wellness programs, the efforts to build healthy settings, varies according to the particular mandate and experience. However, the challenges remain the same.

A strong commitment to developing healthy settings has emerged. The value of collaboration and partnership is central to this development.

This collection of case studies, from a diverse range of "communities" that have developed healthy settings, adds to the repertoire available and encourages further development by Canadians everywhere.

Until one is committed, there is hesitancy, the chance to draw back, always, ineffectiveness, concerning all acts of initiative (and creation). There is one elementary truth the ignorance of which kills countless ideas and splendid plans: that the moment one definitely commits oneself, then providence moves too. All sorts of things occur to help one that would never otherwise have occurred. A whole stream of events issues from the decision, raising in one's favour all manner of unforeseen incidents and meetings and material assistance which no man could have dreamed would have come his way. Whatever you can do or dream you can, begin it. Boldness has genius, power, and magic in it. Begin now!

—Goethe

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APPENDIX A

QUESTIONNAIRE

QUESTIONNAIRE

The following questions provide an outline for describing your process, "model" or "case study." The points listed below each question are intended as guidelines only. Please feel free to expand on them where appropriate.

1. INITIATIVE: IDENTIFYING THE NECESSITY FOR A HEALTHIER SETTING

- Where did the idea for this project or process originate?
- When was it initiated?

2. INITIAL LEADERSHIP

- Who took responsibility for moving the process forward?
  - type of leadership
  - the level of commitment and participation from the organization or setting

3. NEEDS ASSESSMENT

- Was a needs assessment part of the initial process?
  - If yes, whose needs were assessed in establishing the necessity for a healthier setting?
- Please distinguish between needs assessment done for the development of the model or project itself, and needs assessment done at the level of the site (with the actual population).
- What was the outcome of the needs assessment?
- How did this information shape the implementation process ?

4. GOALS OF HEALTH PLAN

- What goals were identified?

5. THE PROCESS AND ACTION PLAN: IMPLEMENTING THE GOALS, ADDRESSING THE NEEDS

- What process did you use/are you using? Please describe the process.
- Could you specify the steps in the process?
- What are the education tools used?

6. ONGOING COMMITMENT AND LEADERSHIP

- How would you describe the level of commitment, ownership and involvement in the process?
    - Management support?
    - Staff?
    - Financial backing?
    - Other resources?

7. THE MODEL/ FRAMEWORK

- Please comment on the approach of this process. Are there a set of principles behind the approach you are taking?
- Is your process one which could be described as a "model"?
- Describe the focus.
- How comprehensive is the process?

8. EVALUATION: REVIEWING THE PROCESS, ITS IMPACT, STRENGTHS AND WEAKNESSES

- Has there been an evaluation of the impact of this process on the workers, the community?
- Describe the evaluation procedure.
- What have you learned about the process from the evaluation?

9. IN YOUR OPINION

- Do you consider this model to be a success? What about it indicates to you that it is successful?
- Please describe your role in shaping the model, and facilitating its use. To what extent are you actually involved in supporting or directing the program after giving it over to the company or setting?
- Who has access to this process/project/model? Please provide a list of the settings which are using the process.
- If you were to plan/implement this project again, how would it be done differently?

APPENDIX B

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